

DEPT.-65

JOB-

21

REEL-

37

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910



CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE
RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT
THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE
DEPARTMENT OF Health BUREAU OF Vital
Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS
AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COM-
PLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PRO-
VIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION
NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN
ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR
ON JUNE 4, 1954.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No.

345

Department:

Health

Bureau:

Vital Statistics

Record Identification

1. TITLE: Certificate of Death		2. Form No. if available		3. Type—(cards, paper, etc.) Bound Book	
4. Dates	5. Volume accumulated yearly	6. Size of Record Misc.	7. Number of copies made One (1)		
8. Authorization Requested (check only one (1) of the squares below)					
A. Establish retention period for <input type="checkbox"/> records which are accumu- lating daily.		B. Dispose of present accumu- lation, no additional accumu- lation anticipated.		C. Microfilm and destroy orig- inals. <input type="checkbox"/>	
				D. Microfilm and retain origi- nals for length of time in- dicated below. <input checked="" type="checkbox"/>	
9. Recommended Retention Period			10. Equipment and space freed.		11. In your opinion does this record have any his- torical significance?
a. In Dept. 12 yrs.	b. In Storage Center Micro. Perm.	c. Total 12 yrs. and Micro. Perm.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes. Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval

Robert E. Fairley, M.D.
Title: Commissioner of Health

3/18/63
Date

Recommendation of Records Management Officer

13. Recommended Retention Period			14. Disposal Method		
a. In Dept. 12 yrs.	b. In Storage Center Microfilm Permanent	c. Total 12 yrs. and Microfilm Permanent	A. To be <input type="checkbox"/> sold as scrap or waste paper	B. To be <input checked="" type="checkbox"/> Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.) <input type="checkbox"/>

REMARKS:

2 negative Rolls

Records Management Officer

C. F. Force

3/18/63
Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM
IN
NUMERICAL ORDER

NOTICE

The succeeding documents
were received in the same
condition and microfilmed
as shown.

Every effort was made to
assure legibility and com-
pleteness.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41798

CERTIFICATE OF DEATH.

92 D41798

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3031 Cedar Ave ST.: 13 WARD)2-FULL NAME William George May

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 3031 Cedar Ave WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 40 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male Whitemarried

5a If married, widowed, or divorced

HUSBAND

(or) WIFE

Margaret E May6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.73

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

Unknown

(State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

Unknown

(State or country)

14

Informant
(Address)Lille Webb
W. 37 St

15

MAR 30 1920

ROBERT E. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 30 1920

17

I HEREBY CERTIFY, That I attended deceased from March 29, 1920, to March 20, 1920.that I last saw him alive on March 29, 1920.and that death occurred, on the date stated above, at 220 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia(duration) yrs. mos. 7 ds.CONTRIBUTORY
(Secondary)Lober Pneumonia(duration) yrs. mos. 3 ds.

18 Where was disease contracted

if not at place of death?

Unknown

Did an operation precede death?

No Date of none

Was there an autopsy?

none

What test confirmed diagnosis?

stethoscope

(Signed)

Wm. Fleury

M. D.

37

(Address) 3705 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Marys HospitalApril 2 1920

20 UNDERTAKER

ADDRESS

Chenoweth Son Chestnut

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41799

CERTIFICATE OF DEATH

1-PLACE OF DEATH

South Baltimore Genl Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

1213 Light

ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mr. Clifton Boone

(Residence in Baltimore: No.

Betteton, Md

St. yrs. mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

May 10, 1909
(Month) (Day) (Year)

7-AGE,

19 yrs. 2 mos. 19 ds.

IF LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Farmer

9-BIRTHPLACE,
(State or Country),

Betteton, Md.

PARENTS.

10-NAME OF FATHER,

John Boone

11-BIRTHPLACE OF FATHER
(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Mattie Leigh

13-BIRTHPLACE OF MOTHER
(State or Country),

Kent Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. John Leigh

(Address) 2321 Jefferson St.

15-

MAR 30 1920

ROBERT E. KEAUTER

Serial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mar 26 1920, to Mar 29 1920,

that I saw him alive on Mar 29 1920,

and that death occurred, on the date stated above, at 11 p.m.

The CAUSE OF DEATH* was as follows:

1. Sanguineous-apoplexy.
2. Cerebral embolism.

(Duration)....yrs....mos....4....ds.

CONTRIBUTORY
(Secondary)

(Duration)....yrs....mos....2....ds.

(Signed) R. P. Requa M. D.

3-29, 1920 (Address) 1213 Light St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Still Pond cemetery

March 30, 1920

20-UNDERTAKER

ADDRESS

Mrs. C. Miller

2334 Jefferson St.

D41800

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41800

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *644 W. Barre*, ST. *22* WARD)

REGISTERED No. C

2-FULL NAME

John P. Townsend

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *644 W. Barre*St.; *53* yrs., *8* mos., *21* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Sept. 8, 1866
(Month) (Day) (Year)

7-AGE,

53 yrs., *8* mos., *21* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Builder*

9-BIRTHPLACE, (State or Country),

Balto.

10-NAME OF FATHER,

Francis Townsend

11-BIRTHPLACE OF FATHER (State or Country),

Balto.

12-MAIDEN NAME OF MOTHER

Lyda Schneider

13-BIRTHPLACE OF MOTHER (State or Country),

Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*Mr. Jno P. Townsend*(Address).....*644 Barre*15-*MAR 30 1920*

ROBERT A. TRAUTMAN

Filed.....191.....*Bariat. Exam. 91000*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr 8 1919, to *Mar 29 1920*,that I saw him alive on *March 28 1920*,and that death occurred, on the date stated above, at *3 9* m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY *Chronic interstitial nephritis*
(Secondary)*t. albuminuria* (Duration) *30 4* yrs.....mos.....ds.(Signed).....*M. B. ...* M. D.*March 29, 1920* (Address).....*426 N. Gilman St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Green Mount March 31, 1920

20-UNDERTAKER

ADDRESS

John Mitchell 2011 W. Key

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41801

CERTIFICATE OF DEATH.

91 D41801

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

522 N. Stricker

ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Frances Snow

(Residence in Baltimore: No.

522 N. Stricker.

St.; 24 yrs., 7 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH,

August 17, 1895..
(Month) (Day) (Year)

7-AGE,

24 yrs., 7 mos., 12 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

House-work

(b) General nature of industry, business, or establishment in which employed (or employer).

At home

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

10-NAME OF FATHER,

James J. Kane

11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore Md.

12-MAIDEN NAME OF MOTHER

Sarah A. Page.

13-BIRTHPLACE OF MOTHER

(State or Country),

Frederick Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sarah A. Kane

(Address) Silver Spring Rd. Fullerton

15-

MAR 30 1920

ROBERT B. REAUTER

Filed

191

Baltimore City Health Department
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

3 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

3/25/20 191, to 3/28/20 191,

that I saw him alive on 3/28/20 191,

and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Philip B. Tauler

M. D.

3/29/20 191... (Address) 1432 William St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Druid Ridge Cemetery

DATE OF BURIAL,

Mar 31, 1920

20-UNDERTAKER

JOHN F. DENNY

ADDRESS

715 LIGHT ST.

D41802

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41802

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 West St. ST. 9 WARD)

2-FULL NAME

Catharine Steele

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

1316 West

ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

James C. Steele

6 DATE OF BIRTH (month, day, and year)

March 20, 1834

7 AGE

Years

86

Months

Days

9

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

At home

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Eda L. Greenwell
1316 West St

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 29 1920

17

HEREBY CERTIFY, That I attended deceased from Jan 31, 1920, to March 6, 1920.That I last saw h. alive on March 6, 1920.and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Acute Dilated heart from symptoms described to me by her daughter

(duration) yrs. mos. ds.

CONTRIBUTORY Chronic Myocarditis
(Secondary) Arteriosclerosis
(duration) 20 yrs. + 7 mos. X ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

No

Date of

X X

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed) O. H. Parker, M. D.

3/29/20 (Address)

958 E North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore team

DATE OF BURIAL

Mar 31 1920

20 UNDERTAKER

Pirkler & Pirkler

ADDRESS

1739 Eager

TION is very important. See instructions on back of card.

MAR 30 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41803

CERTIFICATE OF DEATH.

D41803

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hosp.*)ST.; *25* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *Eganac Warholy**917 Curtis Bay*St.; *40* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED, *Married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Not known
(Month) (Day) (Year)

7-AGE,

60

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....*Shoe maker*
*88*9-BIRTHPLACE,
(State or Country),*Austria*10-NAME OF
FATHER,*Josef Warholy*11-BIRTHPLACE
OF FATHER
(State or Country),*Austria*12-MAIDEN NAME
OF MOTHER*Not known*13-BIRTHPLACE
OF MOTHER
(State or Country),*Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

MAR 30 1920

Robert F. Harrison
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*March**29**1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*3-24**1920*to *3-29**1920*that I saw him alive on *3-29* *1920*and that death occurred, on the date stated above, at *10:00* m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....*J. J. Jones*.....M. D.*Mar. 30, 1920* (Address).....*Hebrew Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *5* ds. In the State yrs. mos. ds.Where was disease contracted,
if not at place of death?Former or
usual residence*917 Curtis Bay*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Holy Cross**Mar. 31 1920*

20-UNDERTAKER

ADDRESS

*Frank Crocker**1706 Ashland*

D41804

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X45 D41804

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

Monument St.

St.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Eldred Jones

(Residence in Baltimore: No.

Hebrew Hospital

St.; ~~Yrs.~~ mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH.

Jan 1st, 1867

7-AGE.

53 yrs. 2 mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Merchant Hardware

9-BIRTHPLACE.
(State or Country),

Va

10-NAME OF FATHER.

Wm S Jones

11-BIRTHPLACE OF FATHER
(State or Country),

Va

12-MAIDEN NAME OF MOTHER

Emily B Lowry

13-BIRTHPLACE OF MOTHER
(State or Country),

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John S. Jones

(Address)

Hampton Va

15-

MAR 30 1920

Robert P. Harrison,

191. Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

March 30, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 27, 1920, to March 30, 1920,

that I saw him alive on March 30, 1920,

and that death occurred, on the date stated above, at 12:45 pm.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

March 27, 1920. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Hampton Va.

Former or usual residence Hampton, Va.

19-PLACE OF BURIAL OR REMOVAL,

Hampton Va

DATE OF BURIAL,

3-30-1920

20-UNDERTAKER

H. Sander & Sons 1700 Bluff St

D41805

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41805

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Carter(a) RESIDENCE. No. 628 W. Biddle St.

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs.

mos.

ds. How long in U. S., if of foreign birth? Life yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

MaleBlackMarried

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Unknown6 DATE OF BIRTH (month, day, and year) 1866

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

54

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown9 BIRTHPLACE (city or town) Virginia

(State or country)

10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Virginia

(State or country)

12 MAIDEN NAME OF MOTHER Sallie Brockston13 BIRTHPLACE OF MOTHER (city or town) Virginia

(State or country)

14

Informant Hospital Records(Address) New City Hospital

15

Filed Robert P. Harrison,

Registrar

MAR 30 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 15, 1920, to March 28, 1920.that I last saw him alive on March 28, 1920.and that death occurred, on the date stated above, at 3:25 P. m.

The CAUSE OF DEATH* was as follows:

Embolic of Liverunknown (duration) yrs. mos. ds.CONTRIBUTORY Broncho - Pneum.

(Secondary)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death?

Date of

Was there an autopsy? yesWhat test confirmed diagnosis? No special test(Signed) A. P. Pearl

M. D.

-28-20 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Not a burials County, March 29

20 UNDERTAKER

ADDRESS

Reel B Pye102 E. Hull St.

D41806

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41806

CERTIFICATE OF DEATH.

PLACE OF DEATH *National W. Harp & Co. Lumber Co.*
CITY OF BALTIMORE (No. *13*) ST. *13* WARD *13*
FULL NAME *Montgomery Whitehead*
(Residence in Baltimore: No. *3519 Benson St.* St. *13* yrs. *8* mos. *1* ds.)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Male</i>	4-COLOR OR RACE, <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <i>Married</i> (Write the word.)
6-DATE OF BIRTH, <i>July 27, 1893</i> (Month) (Day) (Year)		
7-AGE, <i>26</i> yrs. <i>8</i> mos. <i>1</i> ds. If LESS than 1 day, ... hrs. or ... min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work... <i>Lineman</i> (b) General nature of industry, business, or establishment in which employed (or employer)... <i>Gas & Electric Co.</i>		
9-BIRTHPLACE, (State or Country), <i>Montgomery Co. Md.</i>		
PARENTS.	10-NAME OF FATHER, <i>Richard Whitehead</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Howard Co. Md.</i>	
	12-MAIDEN NAME OF MOTHER, <i>Mary Grimes</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Md.</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Ruth S. Whitehead*
(Address) *3519 Benson St.*

15- Robert P. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *3/30/20*, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an...
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said...
(Inquest, au-
topsy or inquiry.)
and that said deceased came to... death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental
Electrocution
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.
(Signed) *Harry L. Smith* M. D.
(Coroner.)
(Address) *1610 E. 13th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Mary's Hospital March 31, 1920

20-UNDERTAKER ADDRESS

Grace Burge & Son 363 Falls Rd.

important. See instructions on back of certificate.

D41807

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41807

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

205 N. Arlington Av 18

ST.; WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Emma Petto

(Residence in Baltimore: No.

205 N. Arlington Av

St.;

35(?)

yrs., moa. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Caucasian

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH,

Mar 25, 1867

(Month)

(Day)

(Year)

7-AGE,

53 yrs. 3 mos. 3 da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

Laundress

(b) General nature of industry, business, or establishment in which employed (or employer).....

41

9-BIRTHPLACE, (State or Country),

Anundel Co

10-NAME OF FATHER,

William Petto

11-BIRTHPLACE OF FATHER (State or Country),

Anundel Co

12-MAIDEN NAME OF MOTHER

Emma Cook

13-BIRTHPLACE OF MOTHER (State or Country),

Anundel Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Walter Schroeder

(Address),

205 N. Arlington Av

15-

MAR 30 1920

Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 28, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 8 1920, to Mar 28 1920,

that I saw her alive on Mar 27 1920,

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration).....yrs.....mos.....da.

CONTRIBUTORY.....Exhaustion.....(Secondary)

(Duration).....yrs.....mos.....da.

(Signed).....H. P. Hughes.....M. D.

3/29, 1920. (Address).....724 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

CMT Auburn

DATE OF BURIAL,

Mar 31, 1920

20-UNDERTAKER

Brown and Ireland Schroeder

D41808

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41808

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3636 Hickory Ave

ST. 13

WARD)

REGISTERED NO. C

2-FULL NAME

Isabella Reed

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 3636 Hickory Ave

St. 3 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Widow

6-DATE OF BIRTH.

Sept 16, 1844

(Month)

(Day)

(Year)

7-AGE.

75 6 14

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

at Home

9-BIRTHPLACE,
(State or Country),

Phila Pa

PARENTS.

10-NAME OF FATHER,

Henry Keys

11-BIRTHPLACE OF FATHER
(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Key L

13-BIRTHPLACE OF MOTHER
(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. John Reed

(Address)

3636 Hickory Ave

15-

Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

March 30, 1920

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

March 18, 1920, to March 30, 1920,

that I saw him alive on March 30, 1920,

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the
Prostate Gland
(Duration) 6 yrs. 6 mos. ds.CONTRIBUTORY
(Secondary)

Ethinism (Duration) 30 yrs. 30 mos. ds.

(Signed)

John Reed M. D.
March 30, 1920 (Address) 3705 Hickory Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Chestnut Mt. March 31, 1920

20-UNDERTAKER

A. J. Marshall 3539 1/2 Rd

MAR 30 1920

D41809

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41809

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St. Joseph's Hosp.

ST.:

WARD)

REGISTERED NO. C.

2-FULL NAME

Mullins, F. J.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

8 W. Glover

St.: 77 yrs., 6 mos., 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, Widow
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Sept 10, 1843

(Month)

(Day)

(Year)

7-AGE,

77 yrs., 6 mos., 20 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

Matthias Stein

11-BIRTHPLACE OF FATHER
(State or Country),

Prussia

12-MAIDEN NAME OF MOTHER

Catherine Smith

13-BIRTHPLACE OF MOTHER
(State or Country),

France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Catherine Stein

(Address)

8 W. Glover St.

15-

Robert P. Harrison,

MAR 30 1920

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March

30

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

3-16 1920, to 3-30 1920

that I saw him alive on 3-30 1920,

and that death occurred, on the date stated above, at 8:45 pm.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration)..... yrs..... mos. 1 ds.

CONTRIBUTORY (Secondary) Cause of

Lung (Duration)..... yrs. 3 mos. ds.

(Signed)..... M. D.

330 1920 (Address) St. Joseph's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos. 14 ds. In the State..... yrs..... mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 8 W. Glover St.

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

Apr. 1, 1920

20-UNDERTAKER

J. A. Moran 3000 E. Balto St.

ADDRESS

D41810

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

81
REGISTERED NO.

D41810

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

916 E. Chase

ST.: 10 WARD)

2-FULL NAME

Ann Flatley

Flatley

(a) RESIDENCE. NO.

916 E. Chase

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

50

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

None

6 DATE OF BIRTH (month, day, and year)

February

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Ireland

10 NAME OF FATHER

Michael Flatley

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Ellen Fitzmaurice

13 BIRTHPLACE OF MOTHER (city or town)

Ireland

(State or country)

14

Informant
(Address)

Ellen Hoster

916 E. Chase St.

15

MAR 3 1 1920

ROBERT S. LAUTER

Registrar

Baltimore Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/30 1920

17

I HEREBY CERTIFY, That I attended deceased from

3/26 1920 to 3/30 1920.

that I last saw him alive on 3/30 1920.

and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows:

Senility
arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Clinical

(Signed) Dr. Bernard Weiss, M. D.

3/30, 1920 (Address) 914 E. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

4/1/20 19

20 UNDERTAKER

ADDRESS

Chas. F. Evans & Son

115 W.

St. Royal

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41811

CERTIFICATE OF DEATH.

150
REGISTERED NO. 6

D41811

1-PLACE OF DEATH

West End Maternity

CITY OF BALTIMORE: (No. _____)

ST.: 19

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Walter H. Goertz Jr.

(Residence in Baltimore: No. _____)

West End Maternity

St.: _____ yrs. _____ mos. _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

m.

4-COLOR OR RACE,

white

5-SINGLE, Married, Widowed, or Divorced. (Write the word.)
Single

6-DATE OF BIRTH,

march 30, 1920
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day,
1...hrs. or....min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.....
-
- (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Balto. Md.

PARENTS.

10-NAME OF FATHER,

Walter H. Goertz

11-BIRTHPLACE OF FATHER (State or Country),

Balto. Md.

12-MAIDEN NAME OF MOTHER

Sadie Kessler

13-BIRTHPLACE OF MOTHER (State or Country),

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Walter Goertz

(Address) 1411 Palapasco St.

15-

Filed

MAR 31 1920

191

ROBERT A. ELLIOTT

Registrar

Burial Permit Class

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Mar 30, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Mar 30, 1920, to Mar 30, 1920,that I saw him alive on Mar 30, 1920,
and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Blue Baby due to
defective Circulatory
apparatus
(Duration) 1 hr.CONTRIBUTORY
(Secondary)

Duration 7 yrs. 7 mos. 7 ds.

(Signed) Shmuel B. Kolman M. D.

101... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cedar Hill Cem Mar 31, 1920

20-UNDERTAKER

ADDRESS

Josiah Sifer 1600 W. North Ave

D41812

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6-09 D41812

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

603 Lafayette Ave.

ST.

WARD)

2-FULL NAME

George William Miller

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

603 Lafayette Ave.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

Dec 9 / 18

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

3

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

George Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Anna Franey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

George Miller 603 Lafayette Ave.

15

Filed

MAR 31 1920

ROBERT E. LEAUTE

Burial Permit Utter

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 31 1920

17

I HEREBY CERTIFY, That I attended deceased from

Mar 19, 1920, to Mar 31, 1920,

that I last saw him alive on Mar 30, 1920,

and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

Bronchitis Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. William T. Key, M. D.

Mar 31, 1920 (Address) 1920 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery

April 1, 1920

20 UNDERTAKER

Martin K. Hays & Sons 1927 W. Long St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41813

D41813

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2216 Christian ST.; 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2216 Christian St.; 5 yrs., 5 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH,

October 8, 1920
(Month) (Day) (Year)

7-AGE,

5 yrs., 22 mos., 22 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Nurse
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Baltimore and

10-NAME OF FATHER,

Frank Eitel

11-BIRTHPLACE OF FATHER

(State or Country), Baltimore

12-MAIDEN NAME OF MOTHER

Rosa Hickey

13-BIRTHPLACE OF MOTHER

(State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. E. J. Eichel(Address) 2216 Christian

15-

MAR 31 1920

ROBERT B. KRAUTER

191. Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 14 1920 to March 29 1920,
that I saw her alive on March 29 1920,
and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Acute Diphtheria

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

Endocarditis, Rheumatism
(Duration).....yrs.....mos.....ds.(Signed) Robert B. Krauter M. D.3/29/20, 1920. (Address) 2151 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.....mos.....ds. In the Stateyrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Ave 3/31/20

20-UNDERTAKER

ADDRESS

John H. Taylor 1111 E. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41814

CERTIFICATE OF DEATH.

108 D41814

PLACE OF DEATH

CITY OF BALTIMORE (No. *20*)

WARD)

*FULL NAME

(Residence in Baltimore: No. *502 Poplar Ave*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *18* mos. *11* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Sept 12, 1901

(Month)

(Day)

(Year)

7-AGE,

1

yrs.,

6

mos.,

18

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

MD

10-NAME OF FATHER,

Henry R. Beyerly

11-BIRTHPLACE OF FATHER,

(State or Country),

MD

12-MAIDEN NAME OF MOTHER,

William Amos

13-BIRTHPLACE OF MOTHER,

(State or Country),

MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

502 Poplar Ave

15-

Filed

MAR 31 1920

ROBERT E. KAUFER

Baptist Parish Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Mar 29, 1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

Inquest, au-

topsy or inquiry find that said deceased came to death

on the day and at the place above.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *John J. Harrison* D.

(Coroner.)

Address *3632 Roland Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the

of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Respot Hill Cem. Cherry Hill Md. 3/31/20

20-UNDERTAKER

*George A. Taylor*Address *1111 N. E. 1st St. N. E.*

important. See instructions on back of certificate.

D41816

139 41816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST.: *9* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Bertha Mc Cullough

(a) RESIDENCE. NO.

1741 Alhambra St.

WARD.

12th

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

May 1-1914

7 AGE

3

Years

10

Months

28

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

W. Mc Cullough

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

M. B. Wistling

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Hospital Reg'd J. H. H.

15

MAR 31 1920

ROBERT A. KRAUTER

BRIAL FAMILIAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 29 1920

17

I HEREBY CERTIFY, That I attended deceased from

*March 28, 1920, to March 29, 1920,*that I last saw her alive on *March 29, 1920,*and that death occurred, on the date stated above, at *6:25 P. M.*

The CAUSE OF DEATH* was as follows:

Acute encephalitis

CONTRIBUTORY (Secondary)

acidosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*Patient's home*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Clinical (over)*(Signed) *W. H. H.*, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oakburn.

DATE OF BURIAL

Apr 1/20 19

20 UNDERTAKER

Robt Turner Inc

ADDRESS

1442 N. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D41817
1-PLACE OF DEATHD41817
REGISTERED NO.CITY OF BALTIMORE: (No. *649 Portland* ST. *22* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Elizabeth Piennes*(a) RESIDENCE. No. *649 Portland* ST. *2* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *40* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April 27 1858*7 AGE Years *60* Months *11* Days *2* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *Brundt*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Don't know*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant *Elizabeth Weiskaar* (Address) *649 Portland*15 File *MAR 31 1920* *ROBERT E. LEADYER* Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 19* 19 *20*17 I HEREBY CERTIFY, that I attended deceased from *Jan 10th 1920* to *March 19th 20* that I last saw him alive on *March 18th 20*and that death occurred, on the date stated above, at *8:12* m.

The CAUSE OF DEATH* was as follows:

*Chronic Rheumatism*CONTRIBUTORY (Secondary) *Hypertension* (duration) yrs. *1* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. E. Glover*

M. D.

Address *1501 E. Bay View*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Cemetery *Mar 31 1920*

20 UNDERTAKER

ADDRESS

for verdons Son *2173 Bk*

TION is very important. See instructions on back of certificate.

D41818

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6 D41818

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *930 Greenmount Ave.* WARD *10*)2-FULL NAME *Catharine M. Wooden*(a) RESIDENCE. No. *930 Greenmount Ave.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 ~~Single~~ Married, Widowed, or Divorced (write the word) *married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Thos. C. Wooden*6 DATE OF BIRTH (month, day, and year) *May 21-1858*7 AGE Years *63* Months *10* Days *9* If LESS than 1 day, *hrs.* or *min.*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Michael Kenney*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Sarah Dugan*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*14 Informant *Thos C. Wooden* (Address) *930 Greenmount Ave.*15 Filed *MAR 31 1920* *ROBERT F. KAUFMAN* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 30 1920*17 I HEREBY CERTIFY, that I attended deceased from *March 27, 1920* to *March 30, 1920*, that I last saw her alive on *March 30, 1920*, and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy(duration) yrs. mos. *3* ds.CONTRIBUTORY *Chronic interstitial nephritis* (Secondary) *Kidneys* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *none*(Signed) *F. A. O'Brien*, M. D., 19 (Address) *1133 Valley St.*

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cathedral**Mar 31 1920*

20 UNDERTAKER

ADDRESS

H. C. Wadfield 914 Greenmount Ave.

TION is very important. See INSTRUCTIONS ON BACK OF CERTIFICATE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41819

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

CERTIFICATE OF DEATH

REGISTERED NO. C

ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAR 31 1920

ROBERT E. LAUTER

191...Boris...01977...Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

that I saw h^e alive onand that death occurred, on the date stated above, at 4:20 p.m.
The CAUSE OF DEATH* was as follows:

Pneumonia

2 weeks (Duration) yrs. mos. ds.

CONTRIBUTORY Influenza
(Secondary)

(Duration) yrs. mos. ds.

(Signed) F. A. Warner M. D.

March 30 1920 (Address) 1133 Valley N.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 11 yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Cathedral

Mar 31, 1920

20-UNDERTAKER

ADDRESS

H. C. Wiedefeld 914 Greenmount

D41820

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 D41820
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *610 Chestnut Hill Ave* WARD) 92-FULL NAME *Robert Frank Munro*(Residence in Baltimore: No. *610 Chestnut Hill Ave* St. *23* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE *Married*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)6-DATE OF BIRTH *March 29, 1920*
(Month) (Day) (Year)7-AGE *57* yrs. *9* mos. *15* ds. or min.?8-OCCUPATION
(a) Trade, profession or particular kind of work *Mechanical engineer*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE
(State or country) *Liverpool, England*10-NAME OF FATHER *Robert Munro*11-BIRTHPLACE OF FATHER
(State or country) *Scotland*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER
(State or country) *Scotland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Robert Munro*(Address) *350 Rosebank Ave*
Baltimore, Md.

MAR 31 1920

ROBERT B. KRAUTH

Filed

191

Baird & Co. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *March 29, 1920*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *January 15, 1920*, to *March 29, 1920*, that I saw him alive on *March 29, 1920*, and that death occurred, on the date stated above, at *10:42* a.m.
The CAUSE OF DEATH* was as follows:
*Carcinoma of Stomach*Contributory
(SECONDARY)(Signed) *C. D. Steensma* M. D.
March 29, 1920 [Address] *3949 Greenmount Ave*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt. Clear

DATE OF BURIAL

Apr 1, 1920

20-UNDERTAKER

Graham, F. Walker

ADDRESS

723 W. Lofgren

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE
CERTIFICATE OF DEATH

REGISTERED NO. C

D41821

PLACE OF DEATH

CITY OF BALTIMORE: (No.)

2-FULL NAME

(Residence in Baltimore: No.)

ST.

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

MAR 31 1920

ROBERT B. BRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I attended deceased from March 23, 1920, to March 31, 1920, that I saw him alive on March 30, 1920, and that death occurred, on the date stated above, at 5:15 A.M.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

20-UNDERTAKER

DATE OF BURIAL

ADDRESS

D41822

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D41822

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 539 Potomac St. (Brooklyn) ST. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ernest J. Ullrich

(a) RESIDENCE. NO.

539 Potomac St. (Brooklyn) ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos.

ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Emma J. Ullrich

6 DATE OF BIRTH (month, day, and year) April 21 1877

7 AGE

42

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

Carpenter

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

House

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER Karl Ullrich

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Emma J. Ullrich

539 Potomac St. (Brooklyn)

15

MAR 31 1920

ROBERT E. KAUFMAN

Burial Permit 01078

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1920, to March 28, 1920, that I last saw him alive on March 28, 1920, and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis with Mitral Incompetence, Pneumonia, Rheumatic Fever

(duration) yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death?

at place of death

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Physical Findings

(Signed)

3/31/1920 Address 12150 Danvers St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cedar Hill Cemetery

DATE OF BURIAL

Mar. 31 1920

20 UNDERTAKER

JOHN F. DENNY

ADDRESS

715 LIGHT ST.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41823

CERTIFICATE OF DEATH

82 D41823

1-PLACE OF DEATH

Bayview Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST. 11

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Ulda Howard.

(Residence in Baltimore: No.

110 Center St.

St. 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Black

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH.

March 9, 1859

(Month)

(Day)

(Year)

7-AGE,

61

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER
(State or Country),

Do.

12-MAIDEN NAME OF MOTHER

Do.

13-BIRTHPLACE OF MOTHER
(State or Country),

Do.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Bayview Hosp.

(Address).

Baltimore, Md.

15-

Filed.

MAR 31 1920

ROBERT B. LAUTER

Social Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

March 28, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 9, 1920, to March 28, 1920,

that I saw him alive on March 28, 1920,

and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH was as follows:

Cerebral Thrombosis

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

Senile Dementia

(Duration) yrs. mos. ds.

(Signed) H. G. Smith, M.D.

3/29/20 (Address) Bayview Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Auburn Cem

March 31, 1920

20-UNDERTAKER

ADDRESS

Daniel Easton

916

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41824

CERTIFICATE OF DEATH.

D41824

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Maryland Penitentiary

WARD)

2-FULL NAME

Charles E. Hill

(Residence in Baltimore: No.

623 Greenwillow

St.; 26 yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH,

Unknown 1 (Month) (Day) (Year)

7-AGE,

26 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

General Laborer

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

PARENTS.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John F. Leonard, Warden

(Address)

Md. Penitentiary

15-

MAR 31 1920

ROBERT E. LAUTER

Filed

191

Serial Permit 4-4-1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 29, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 21 1920, to March 29 1920, that I saw him alive on March 28 1920, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Insanition - Toxicemia - Acute mania

(Duration) yrs. mos. ds. 8 mos. 8 ds.

CONTRIBUTORY (Secondary)

General Paresis - Syphilis

(Duration) yrs. mos. ds. 2 mos. 7 ds.

(Signed) William F. Schwartz M. D.

3/29, 1920 (Address) Md. Penitentiary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 623 Greenwillow St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt. Auburn Cem. March 31, 1920

20-UNDERTAKER

Daniel Easton

ADDRESS

Same

HEALTH DEPARTMENT—CITY OF BALTIMORE

041825

CERTIFICATE OF DEATH.

151 D41825

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE,

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

march 30, 1920
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day,
.....yrs.....mos.....ds. 13 hrs. or.....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....9-BIRTHPLACE,
(State or Country),

Balto.

PARENTS.

10-NAME OF
FATHER,

William L. Braunstein

11-BIRTHPLACE
OF FATHER
(State or Country),

Balto. Md.

12-MAIDEN NAME
OF MOTHER

Rose A. Miller

13-BIRTHPLACE
OF MOTHER
(State or Country),

Hanford Conn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-MAR 31 1920

ROBERT B. ELAFTER

Filed....., 191.....

Burial Permit Order
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

march 30, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

march 30, 1920, to march 30, 1920,

that I saw him alive on march 30, 1920,

and that death occurred, on the date stated above, at 9:00 m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

Premature birth

(Duration).....yrs.....mos.....ds.

(Signed) Harry Loebman, M.D.

3/30, 20 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew Mt. Carmel....., 1920

20-UNDERTAKER

ADDRESS

Jack Lewis, 1411 E. Balto.

D41826

28✓ D41826

REGISTERED NO. C

ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

20

St.: yrs. mos. ds.)

(Residence in Baltimore: No. 928 Vincent St.

CORONER'S CERTIFICATE OF DEATH.

4-COLOR OR RACE,
Colored

5-SINGLE,
MARRIED, Married
WIDOWED,
OR DIVORCED,
(Write the word.)

16-DATE OF DEATH.

..March..28..1920, 191..
Month) (Day) (Year)

6-DATE OF BIRTH.

Sept. 14, 1881.
(Month) (Day) (Year)

7-AGE.

39 yrs. 6 mos. 14 ds.

IF LESS than 1 day,
....hrs. or....mlu.?

S-OCCUPATION:

(a) Trade, profession, or particular kind of work.....Janitor

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country) Maryland

10-NAME OF FATHER, Dick Murray

11-BIRTHPLACE
OF FATHER Maryland
(State or Country).

12-MAIDEN NAME OF MOTHER Elsie Locks

13-BIRTHPLACE
OF MOTHER
(State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Emma Murray.....

(Address).....928 Vincent St.....

15- MAR 31 1920 ROBERT E. KAUFER
Filed....., 191..... Berlin, Prussia, Germany

17- I HEREBY CERTIFY, That I took charge of the
remains described above, held an Inquiry.....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, au-

Inquiry.....and that said deceased came to ^{His} death
(topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

.....Pulmonary Hemorrhage.....
.....Probably T. B.

(Duration).....yrs.....mon.....ds

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.
(Signed) J. Edw. Dineen M. D.
(Coroner)
9/30, 1970. (Address) 905 E. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place _____ In the _____
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, **DATE OF BURIAL**
Interred here **MAR 31 1920**

20-UNDERTAKER ADDRESS
JAMES H. DENNIS

1903 FREESTMAN ST.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41827

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Fem

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH,

Sept

16

1884

(Month)

(Day)

(Year)

7-AGE,

35

yrs.

6 mos.

ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

R.R. Ticket

(b) General nature of industry, business, or establishment in which employed (or employer).

Clerk

9-BIRTHPLACE, (State or Country),

Ballo Md

PARENTS.

10-NAME OF FATHER,

Eugene D Smith

11-BIRTHPLACE OF FATHER

(State or Country),

Ballo. Md.

12-MAIDEN NAME OF MOTHER

Rachel Kitto

13-BIRTHPLACE OF MOTHER

(State or Country),

Ballo. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lulu K. Smith

(Address)

Carroll Rd & Kennedy Ave

15-

MAR 31 1920

ROBERT R KRAUTER

Filed....., 191

Burial Form No. 0444

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March

30

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 25, 1920, to March 30, 1920,

that I saw her alive on March 30, 1920,

and that death occurred, on the date stated above, at 12:45 p.m.

The CAUSE OF DEATH* was as follows:

Influenza

Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY

(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Leonard Beach M. D.

March 30, 1920 (Address) 1 E. 21 St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

London Park

April 1, 1920

20-UNDERTAKER

ADDRESS

George Smith

5000 25

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D41828

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *John H. Snyder Hosp. ST.* 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John H. Snyder

(a) RESIDENCE

Richsville Ohio ST. WARD. *Richsville Ohio*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Agnes D. Snyder*

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

59

Years

Months

Days

If LESS than
1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Miner*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Pa*

10 NAME OF FATHER

*Henry Snyder*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Pa*

12 MAIDEN NAME OF MOTHER

*Margaret Fritz*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Pa*

14

Informant
(Address)*Hospital Record
J. H. H.*

15

Filed

MAR 31 1920

ROBERT E. BRAUTER

Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 30 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 27 1920 to March 30 1920.*that I last saw him live on *March 30, 1920.*and that death occurred, on the date stated above, at *12⁰⁰* m.

The CAUSE OF DEATH* was as follows:

Cancer of glands of neck(duration) *3* yrs. mos. ds.CONTRIBUTORY
(Secondary)*Syphilis*(duration) yrs. mos. *10* ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *yes*(Signed) *Arthur J. Ford*, M. D.19 (Address) *John Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Wheeling W. Va.**March 31 1920*

20 UNDERTAKER

ADDRESS

*J. J. Harris & Co.**221 N. Broadway*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41829

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1522 McCulloh ST. 14 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1522 McCulloh St.; 17 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

7

4-COLOR OR RACE,

C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) M

6-DATE OF BIRTH,

Jan 16, 1893
(Month) (Day) (Year)

7-AGE,

27 yrs., 2 mos., 13 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...House Wife
Ex School Teacher9-BIRTHPLACE,
(State or Country),

Norfolk Va.

10-NAME OF FATHER,

Rev Abraham L. Gaines

11-BIRTHPLACE OF FATHER
(State or Country),

Georgia

12-MAIDEN NAME OF MOTHER

Minnie L. Plant

13-BIRTHPLACE OF MOTHER
(State or Country),

Georgia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Rev N. L. Gaines
(Address) 1524 McCulloh

15-

Filed

MAR 31 1920

ROBERT B. ELLISTON

Baltimore Permit Office

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 29, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 26, 1920, to March 29, 1920,

that I saw her alive on March 29, 1920,

and that death occurred, on the date stated above, at... m.

The CAUSE OF DEATH* was as follows:

Diphtheria Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) W. H. Wright M. D.

Mar. 29, 1920 (Address) 1207 Presb.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Mt Zion bury

Mar. 30, 1920

20-UNDERTAKER

ADDRESS

George H. Holland

1631 14th

Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41830

CERTIFICATE OF DEATH.

104 D41830

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1342* *Coachman* ST. *15* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Charles Edward Huson Jr.*(a) RESIDENCE. NO. *1342* *Coallum* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. *2*mos. *22*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan. 8, 1920*

7 AGE

Years

Months

Days

If LESS than

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *1342* *Coallum St* (State or country) *Baltimore Md.*10 NAME OF FATHER *Charles Edward Huson*11 BIRTHPLACE OF FATHER (city or town) *Balto Co.* (State or country)12 MAIDEN NAME OF MOTHER *Leonora Hall*13 BIRTHPLACE OF MOTHER (city or town) *Salem N. C.* (State or country)

14

Informant *Charles Edward Huson* (Address) *1342 Coallum St*

15

*MAR 31 1920**ROBERT E. TRAUTER*Burial Permit *1631*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 20 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*March 25, 1920, to March 20, 1920,*that I last saw him alive on *March 20, 1920,*and that death occurred, on the date stated above, at *4:20 P. m.*

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(duration)

yrs. *2*mos. *7*

ds.

(duration)

yrs. *1*mos. *7*

ds.

18 Where was disease contracted if not at place of death?

1342 Coallum St

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical

(Signed)

Wm. H. Meyer

M. D.

(Address) *1209 Pressman*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*MD Zion Chrch**Apr 1 1920*

20 UNDERTAKER

ADDRESS

*George H. Holland**1631 Coallum St*

D41831

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41831

CERTIFICATE OF DEATH.

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *2637 Frederick Ave.* ST. *20*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Baby Montague

(Residence in Baltimore: No.

2637 Frederick Ave.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

March 27, 1920.
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

None

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

10-NAME OF FATHER,

Raymond Java

11-BIRTHPLACE

OF FATHER

(State or Country),

unknown

12-MAIDEN NAME

OF MOTHER

Julia Montague

13-BIRTHPLACE

OF MOTHER

(State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Fannie Allen

(Address),

2637 Frederick Ave.

15-

*Robert P. Harrison,**Registrar.*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 27, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the
remains described above, held an *inquiry*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquiry*
(Inquest, au-*inquiry* and that said deceased came to *death*
topsy or inquiry *on the day stated above.*

The CAUSE OF DEATH* was as follows:

Asphyxiation born
without any attention.
(Duration) *...* yrs. *...* mos. *...* ds.CONTRIBUTORY
(Secondary)(Duration) *...* yrs. *...* mos. *...* ds.(Signed) *F. E. Harrison* M. D.
(Coroner.)*2637* 191... (Address) *410 Lexington**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran-
sients, or Recent Residents).At place In the
of death *...* yrs. *...* mos. *...* ds. State *...* yrs. *...* mos. *...* ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

HOPKINS HOSPITAL

20-UNDERTAKER

ADDRESS

*Commissioner Health.**MAR 29 1920*

important. See instructions on back of certificate.

MAR 31 1920

101 Registrar.

D41832

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41832

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 W. Montgomery ST.: 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Joseph Myers

(a) RESIDENCE. NO.

112 W. Montgomery ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

? yrs. ? mos. ? ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

37

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

MAR 31 1920

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 1920

17 I HEREBY CERTIFY, That I attended deceased from

Mar 20 1920 to Mar 23 1920that I last saw him alive on Mar 23 1920and that death occurred, on the date stated above, at 3:15 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) Unknown ds. Probably 6 mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 2Was there an autopsy? NoWhat test confirmed diagnosis? None other than physical(Signed) B. Harrison M. D.3/18/20 (Address) 140 W. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY.

DATE 3/31/20 SERIAL 19

20 UNDERTAKER

Commissioner of Health, Per. Wm. E. Womack.

ADDRESS

D41833

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41833

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 725 Brannan Court. ST. 22 WARD)

REGISTERED NO. C

2-FULL NAME

Henry Banner. (C)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

725 Brannan Court.

St.: yrs. 70 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male. 4-COLOR OR RACE, Colored. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single. (Write the word.)

6-DATE OF BIRTH, Do not know. / (Month) (Day) (Year)

7-AGE, 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

Loborer.

9-BIRTHPLACE, (State or Country).

Baltimore, Md.

10-NAME OF FATHER,

Do not know.

11-BIRTHPLACE OF FATHER (State or Country),

Do not know.

12-MAIDEN NAME OF MOTHER

Do not know.

13-BIRTHPLACE OF MOTHER (State or Country),

Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Garnett. (C)

(Address) 725 Brannan Court.

15-

Robert B. Harrison

MAR 31 1920

101

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 21th. 1920. 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above. (Inquest, au- topsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Bernhard (Coroner.)

March 24 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

PUBLIC CEMETERY.

19....

20-UNDERTAKER

ADDRESS

Commissioner Health,

MAR 31 1920

Per. Wm. E. WOODALL

important. See instructions on back of certificate.

D41834

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41834

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Murder*)ST. *17* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *423 N. Pine*

(Usual place of abode)

ST. *17* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *61* yrs. *3* mos. *4* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Negro* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *12/25/1858*7 AGE Years *61* Months *3* Days *4* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Cook* *021*(b) General nature of industry, business, or establishment in which employed (or employer) *Private*(c) Name of employer *Family*9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Ind.*10 NAME OF FATHER *Wilbur*11 BIRTHPLACE OF FATHER (city or town) *Ind.* (State or country)12 MAIDEN NAME OF MOTHER *Elyza*13 BIRTHPLACE OF MOTHER (city or town) *Ind.* (State or country)

14

Informant (Address) *George Harrison**Robert M. Harrison*

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/24* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from *3/27*, 19 *20*, to *3/24*, 19 *20*, that I last saw him alive on *3/24*, 19 *20*, and that death occurred, on the date stated above, at *8:15 a. m.* The CAUSE OF DEATH* was as follows:*Unnatural death - strangulation of*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Port of entrance shock*

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No*Date of *3/27/20*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Samuel D. Podgich*

M. D.

19 (Address) *Murder*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mr. Auburn Lee**Apr 1 1920*

20 UNDERTAKER

ADDRESS

*Samuel H. Hoadley**578 W. 11th*

MAR 31 1920

D41835

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41835

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *11*)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)
Length of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

negro

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Wife of Daniel Farnell

6 DATE OF BIRTH (month, day, and year)

7 AGE

51

11

28

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

MD.

10 NAME OF FATHER

Walter

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Walter

12 MAIDEN NAME OF MOTHER

Walter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Walter

14 Informant
(Address)

Daniel Farnell
3420 N. of Pennsylvania
Robert J. Harrison,
Registrar

ST.: *11*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. WARD.
(If nonresident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 31, 1920*

17 I HEREBY CERTIFY, That I attended deceased from *March 14, 1920* to *March 31, 1920*
that I last saw him alive on *March 31, 1920*
and that death occurred, on the date stated above, at *7:45 a. m.*
The CAUSE OF DEATH* was as follows:

Myocarditis

CONTRIBUTORY
(Secondary)

Pulmonary Tuberculosis

18 Where was disease contracted
if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

Samuel J. P. Pugh M. D.

3/31/1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Ambrose Cem

DATE OF BURIAL

Apr. 3, 1920

20 UNDERTAKER

Samuel J. Pugh

MAR 31 1920

Burial Permit Clerk

D41836

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41836

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4713 Ready Ave. ST. 27 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Tate Mc Kinley

(Residence in Baltimore: No. 4713 Ready Ave.

St.; 64 yrs., 10 mos. 15 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, married (Write the word.)

6-DATE OF BIRTH, Mar. 15, 1855 (Month) (Day) (Year)

7-AGE, 64 yrs., 10 mos., 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Cake Salesman (b) General nature of industry, business, or establishment in which employed (or employer), 666

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, William Mc Kinley

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER, Maria A.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Mc Kinley

(Address) 5316 Ready Ave.

15- Robert B. Harrison

MAR 31 1920

191

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 30, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 9 1920, to March 30 1920, that I saw him alive on March 30 1920, and that death occurred, on the date stated above, at 10:30 AM

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Arterio-sclerotic and Natural Insufficiency

(Duration) 20 yrs., 3 mos., 3 ds.

CONTRIBUTORY (Secondary) As: cardiac dilatation

(Duration) 9 yrs., 5 mos., 6 ds.

(Signed) George W. T. Bishop, M. D.

March 20, 1920 (Address) 801 Sheridan Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 64 yrs., 10 mos., 15 ds. In the State 64 yrs., 10 mos., 15 ds.

Where was disease contracted, Same.
if not at place of death?

Former or usual residence Same

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Presbyterian Graves April 1, 1920

20-UNDERTAKER, ADDRESS

William Cook 502 E. North Ave.

D41837

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41837

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1830 N-Castle ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

1830 N-Castle ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)Married6a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofJohn E. Slade

6 DATE OF BIRTH (month, day, and year)

March 23-1872

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.48-6

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workAt Home(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town,
State or country)Balto Md

10 NAME OF FATHER

Samuel W. C. Laughlin11 BIRTHPLACE OF FATHER (city or town,
State or country)Balto Md

12 MAIDEN NAME OF MOTHER

Agnes Stewart13 BIRTHPLACE OF MOTHER (city or town,
State or country)Balto Md

14

Informant
(Address)John E. Slade
1830 N-Castle

15

MAR 31 1920¹⁹

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 23, 1920, to March 24, 1920,that I last saw her alive on March 23and that death occurred, on the date stated above, at 305 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis(duration) yrs. mos. 6 ds.CONTRIBUTORY
(Secondary)(duration) yrs. mos. 1 ds.18 Where was disease contracted
If not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? yes(Signed) Wolfe C. Everhart M. D.Address 2201 N. E. Ave., Balto, Md.*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Greenmount

DATE OF BURIAL

April 1-1920

20 UNDERTAKER

Wm. Cooke

ADDRESS

507 E. North

D41838

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41838

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 S. Caroline ST.; 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 311 S. Caroline St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Male</u>	4-COLOR OR RACE, <u>col</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <u>Single</u>
6-DATE OF BIRTH, 1880 (Month) (Day) (Year)		
7-AGE, <u>40</u> yrs., mos., ds.		16-LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer).....		

9-BIRTHPLACE,
(State or Country), Leam

PARENTS.	10-NAME OF FATHER, <u>?</u>
	11-BIRTHPLACE OF FATHER (State or Country), <u>?</u>
	12-MAIDEN NAME OF MOTHER, <u>?</u>
	13-BIRTHPLACE OF MOTHER (State or Country), <u>?</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed

MAR 31 1920

Robert P. Harrison
Registrar.

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

March 27, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from 23/3/20 1920, to 27/3/20 1920, that I saw him alive on 27/3/20 1920 and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Violence, myocarditis
Abnormal
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY
(Secondary)Sudden death
Several hours
(Duration)..... yrs..... mos..... ds.
(Signed)..... M. D.
27/3/20 (Address).....*State the DISEASE CAUSING DEATH, or, in deaths from ACCIDENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

JOHNS HOPKINS HOSPITAL....., 1920

20-UNDERTAKER

ADDRESS

Commissioner Health,

Per. Wm. E. WOODALL.

MAR 29 1920

041839

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST.: *18th* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *70 City of Baltimore* ST.: *18th* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*2.*6 DATE OF BIRTH (month, day, and year) *Feb. 2 - 1919*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1**10**21*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

2 100

(c) Name of employer

2

9 BIRTHPLACE (city or town) (State or country)

*Baltimore**md.*

10 NAME OF FATHER

Alfred Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

2.

12 MAIDEN NAME OF MOTHER

Ida. (dear)

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

2.

14

Informant (Address)

2. 11th Records

15

Filed

Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 23 - 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*March 22 - 1920, to March 23, 1920.*that I last saw him alive on *March 23, 1920.*and that death occurred, on the date stated above, at *940 P. m.*

The CAUSE OF DEATH was as follows:

acute intestinal indigestion (diarrhoea)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Florence Crittenden*Did an operation precede death? *no* Date of *—*Was there an autopsy? *yes*What test confirmed diagnosis? *Clinical diagnosis*(Signed) *W. H. Haff* M. D.19 (Address) *100*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

*Commissioner Health.**MAR 2 1920*

MAR 31 1920

Burial Permit Blank

D41840

Spec. 6-9-19-H.P. Co. 1000 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41840

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST.: *6* WARD)

2-FULL NAME

Louise Fowler

(a) RESIDENCE. NO.

422 N. Bond St. ST.: *12th* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Child*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Child*6 DATE OF BIRTH (month, day, and year) *April 8-1918*7 AGE Years *11* Months *18* Days *18* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.* (State or country)10 NAME OF FATHER *Robt. Proctor*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country)12 MAIDEN NAME OF MOTHER *Thel Fowler*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country)14 Informant *Hospital* (Address) *Johns Hopkins Hospital*15 Filed *Mar 31 1920* 16 *Robert M. Harrison* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 26 1920*17 I HEREBY CERTIFY, That I attended deceased from *March 26*, 1920, to *March 26*, 1920, that I last saw her alive on *March 26*, 1920, and that death occurred, on the date stated above, at *9:45 P.* m. The CAUSE OF DEATH was as follows:*Tubercular pneumonia*CONTRIBUTORY (Secondary) *Hereditary Syphilis* (duration) yrs. mos. ds.18 Where was disease contracted *Patient home* If not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Clinical work*(Signed) *Wm. E. Woodall*, M. D.19 (Address) *1111 N. Bond St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *JOHNS HOPKINS HOSPITAL* DATE OF BURIAL *Mar 29 1920*20 UNDERTAKER *Commissioner Health* ADDRESS *Mar 29 1920*Per *Wm. E. Woodall*

Burial Permit Clerk.

TION is very important. See instructions on back of certificate.

D41841

Spec.—5-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *21st* WARD)2-FULL NAME *Roberta Adams*(a) RESIDENCE. NO. *210 Otterbein St.* ST. *1* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

*Colored*5 Single, Married, Widowed,
or Divorced (write the word)*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*2*6 DATE OF BIRTH (month, day, and year) *Sept. 24-1919*

7 AGE

Years

Months

Days

If LESS than
1 day,.....hrs.
or.....min.*6**2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Child*(b) General nature of industry,
business, or establishment in
which employed (or employer)*000*

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Maryland*10 NAME OF FATHER *John Thomas Adams*

PARENTS

11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Maryland*12 MAIDEN NAME OF MOTHER *Ann Smith*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Maryland*

14

Informant
(Address)*J.H.H. Adams*

15

Filed

19

MAR 31 1920

Robert P. Harrison Registrar

Burial Permit Clerk

D41841

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 26* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

*Mar 10*19 *20*, to *Mar 26*19 *20*.that I last saw him alive on *Mar 26*.19 *20*.and that death occurred, on the date stated above, at *438* a. m.

The CAUSE OF DEATH* was as follows:

*Meningeococcal Meningitis*CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

Internal hydrocephalus

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?*Patent home*Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

Spinal fluid

(Signed)

Chas. J. ... M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

MAR 26 1920

20 UNDERTAKER

Commissioner Health.

ADDRESS

Wm. E. WOODALL

D41842

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41842

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 M Maderia ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John James(Residence in Baltimore: No. 703 N Maderia st St.; 39 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married
(Write the word.)6-DATE OF BIRTH, Unknown, 1868
(Month) (Day) (Year)7-AGE, 52 yrs., mos., ds. If LESS than 1 day, hrs. or min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer), Build days9-BIRTHPLACE, (State or Country), BohemiaPARENTS.
10-NAME OF FATHER, John James
11-BIRTHPLACE OF FATHER (State or Country), Bohemia
12-MAIDEN NAME OF MOTHER, Mary Currell
13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Scott(Address) 703 N Maderia st

15-

MAR 31 1920 Robert P. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 31, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from March 15 1920, to March 30 1920, that I saw him alive on March 30 1920, and that death occurred, on the date stated above, at 16 m.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., ds.
(Signed) J. J. Valentini M. D.
March 31, 1920 (Address) 16 S. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence 19-PLACE OF BURIAL OR REMOVAL, Holly RedemonDATE OF BURIAL, Apr. 3, 192020-UNDERTAKER, Frank Conch & SonsADDRESS, 1906 Adolphi

141843

P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41843

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. ST. 14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred *8 yrs.*

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD *12th*

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored Child

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced.
HUSBAND of
(or) WIFE of*Child*

6 DATE OF BIRTH (month, day, and year)

Nov 25-1919

7 AGE

Years

4

Months

4

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Joe Finnerel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Mary Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Hospital Record

15

Filed

19

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

March 29 1920

17

I HEREBY CERTIFY, That I attended deceased from

*March 12, 1920, to March 24, 1920.*that I last saw him live on *March 29, 1920.*

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

acute military tuberculosis(duration) yrs. *1* mos. *?* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. *2* mos. *?* ds.

18 Where was disease contracted if not at place of death?

Patent Store

Did an operation precede death?

No

Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Clinical autopsy

(Signed)

W. H. H.

M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

19

20 UNDERTAKER

ADDRESS

*W. H. H. 1200 N. WOOD**MAR 31 1920*

Burial Permit Clerk

D41844

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41844

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1014 W. La Fayette.

ST.; 16 WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Jno. D. Blake

(Residence in Baltimore: No.

1014 W. La Fayette

St.; 47 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

November 3, 1854

(Month)

(Day)

(Year)

7-AGE,

66

4

mos.

27

ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Surgeon

(b) General nature of industry, business, or establishment in which employed (or employer).

154

9-BIRTHPLACE,

(State or Country),

Va.

10-NAME OF FATHER,

John H. Blake

11-BIRTHPLACE OF FATHER

(State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Emily A. Lumpkin

13-BIRTHPLACE OF MOTHER

(State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Sherbert C. Blake, Jr.

(Address)...

1014 W. La Fayette.

15-

Robert P. Harrison,

Filed

MAR 31 1920

191

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Mar. 30, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mar. 1, 1920, to Mar. 30, 1920,

that I saw him alive on Mar. 30, 1920,

and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration)...

yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration)...

yrs. mos. ds.

(Signed)...

Sherbert C. Blake, Jr.

M. D.

Mar. 30, 1920 (Address) 1014 W. La Fayette.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mill Creek, Va.

DATE OF BURIAL,

April 1, 1920

20-UNDERTAKER

Wm. Tucker & Sons

ADDRESS

North Ave.

D41845

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41845

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *West End Maternity*

REGISTERED NO. C

CITY OF BALTIMORE: (No. _____)

ST.: _____

WARD) _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Elizabeth Louise Maring*

(Residence in Baltimore: No. _____)

St.: _____ yrs. _____ mos. _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

March 22, 1920
(Month) (Day) (Year)

7-AGE,

8 yrs. _____ mos. _____ ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Balto, Md.

10-NAME OF FATHER,

Earl Wilson Maring

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Evelyn Williams

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *E. P. Maring*(Address) *Lynsille St.*

15-

Robert P. Harrison,

Filed

191

MAR 31 1920

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I saw h alive on 191,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

over
Myocardial Infarction - Sub-
acute - Branchial gland

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Bernard Daniel Mearns* M. D.*Mar. 31, 1920. (Address) 1029 Lexington*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Carland Ind April 9, 1920

20-UNDERTAKER

ADDRESS

Jas. R. Meier Lynsille

D41846

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D41846

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 707 N Fremont St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emeline annil Morgan(Residence in Baltimore: No. 707 N Fremont St. 14 yrs. 14 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE Widowed
MARRIED
WIDOWED
OR DIVORCED
(Write the word)6-DATE OF BIRTH May 4, 1835
(Month) (Day) (Year)7-AGE 84 yrs. 10 mos. 27 ds. or min.?
If LESS than 1 day, hrs. min.?8-OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none9-BIRTHPLACE (State or country) Maryland10-NAME OF FATHER Nichols Worthington11-BIRTHPLACE OF FATHER (State or country) Maryland12-MAIDEN NAME OF MOTHER Matilda C. Dell13-BIRTHPLACE OF MOTHER (State or country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Matilda Covey(Address) 707 N Fremont St.

15- Robert F. Harrison,

MAR 31 1920
Burial Permit REGISTAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH March 30, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Jan 6, 1920, to, March 30, 1920, that I saw her alive on March 30, 1920, and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Old age infirmitiesContributory (SECONDARY) Cardiac asthma
(Duration) yrs. mos. ds. 5
(Signed) Geo. W. Lumsden M. D.
Oct 31, 1912. [Address] 800 Herborn Ave.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Brown Ridge Cemetery April 1, 192020-UNDERTAKER ADDRESS
Wilbur W. Shriver 1018 Edmondson

TION is very important. See instructions on back of certificate.

D41817

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41817

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 135 S. Catherine ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Jubb

(a) RESIDENCE. No. 135 S. Catherine ST.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

life 58 - 11 - 25

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Emma Jubb

6 DATE OF BIRTH (month, day, and year)

ap 5 - 1862

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

58

11

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Richard Jubb

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Debra William

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md

14

Informant (Address)

Mrs. Nina Blunt
135 S. Catherine St.

MARCH 1 1920

Robert F. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 31 1920

17

I HEREBY CERTIFY, That I attended deceased from

ap 1 - 1918, to Mch 31 1920

that I last saw him alive on Mch 30 1920

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Unknown

CONTRIBUTORY (Secondary)

Coma

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

3/31 1920

(Address)

Chas. C. Conner, M. D.
1101 N. Fulton A

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cemetery

April 2 1920

20 UNDERTAKER

J. B. Neffert 2236 Fredk St

D41848

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41848

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 439 Furrow ST.; 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernia M. Dorsey(a) RESIDENCE. NO. 439 Furrow ST., 70 WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? 1 yrs. 1 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female WhiteSingle5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____6 DATE OF BIRTH (month, day, and year) Mar 23, 1911

7 AGE

Years

Months

Days

If LESS than 1 day, 1 hrs. or 1 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000(b) General nature of industry, business, or establishment in which employed (or employer) _____(c) Name of employer _____9 BIRTHPLACE (city or town) (State or country) Baltimore - Md10 NAME OF FATHER Mr. J. Dorsey11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore - Md12 MAIDEN NAME OF MOTHER Ruth McDermott13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore - Md

14

Informant (Address) Mr. J. Dorsey
439 Furrow St

15

Robert P. Harrison, Registrar

MAR 31 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1920

17

I HEREBY CERTIFY, That I attended deceased from

Mar 27, 1920, to Mar 30, 1920that I last saw her alive on Mar 30, 1920and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia(duration) 4 yrs. 4 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) 4 yrs. 4 mos. 4 ds.18 Where was disease contracted if not at place of death? in houseDid an operation precede death? no Date of _____Was there an autopsy? noWhat test confirmed diagnosis? _____(Signed) Walter B. Keop, M. D.19 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western CemeteryMar 31

20 UNDERTAKER

ADDRESS 2236 Fredk St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41849

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Hill (Sarah Tilman)(a) RESIDENCE. NO. 400 Lewis St.
(Usual place of abode)ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of Walter Hill
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18937 AGE Years Months Days If LESS than 1 day, hrs. or min.
27 — —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown(b) General nature of industry, business, or establishment in which employed (or employer) at home(c) Name of employer son in9 BIRTHPLACE (city or town) Balto
(State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown14 Informant Hospital Records
(Address) H.T.H.15 File APR 1 - 1920 ROBERT H. KAUTER

Burial Permit 01076

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 192017 I HEREBY CERTIFY, That I attended deceased from March 26, 1920, to March 30, 1920, that I last saw or alive on March 29, 1920, and that death occurred, on the date stated above, at 7.15 A. M.

The CAUSE OF DEATH* was as follows:

Conjunctive lobular pneumoniaCONTRIBUTORY Pylo nephritis bilateral
(Secondary) (duration) yrs. mos. ds. 8(duration) yrs. mos. ds. 318 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George W. Wilkins, M. D.3-30-20 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laurel cemetery

DATE OF BURIAL

4, 2, 20

20 UNDERTAKER

Mrs R. ElliottADDRESS 1725ashland

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41850

CERTIFICATE OF DEATH.

79 D41850

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2245 Eastern Ave* ST.; *1* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Duncan Williams*(Residence in Baltimore: No. *266 S. Duncan* St.; *23* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *Negro* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH, *—*, *1*, *—*
(Month) (Day) (Year)

7-AGE *50* yrs., *—* mos., *—* ds. If LESS than 1 day, *—* hrs. or *—* min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *House-work*
(b) General nature of industry, business, or establishment in which employed (or employer). *At Home*

9-BIRTHPLACE, *in Baltimore 23 years*
(State or Country), *in Connecticut*

10-NAME OF FATHER, *John Draper*
11-BIRTHPLACE OF FATHER (State or Country), *Connecticut*
12-MAIDEN NAME OF MOTHER, *Susan Draper*
13-BIRTHPLACE OF MOTHER (State or Country), *Connecticut*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Williams*
(Address) *266 S. Duncan St.*

15- *ROBERT R. RAUTER*

Filed *APR 1 - 1920* *Bureau of Health*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *March 28, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *March 28, 1920*, to *March 28, 1920*, that I saw him alive on *March 28, 1920*, and that death occurred, on the date stated above, at *10* m. The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart

(Duration) *2* yrs., *—* mos., *—* ds.
CONTRIBUTORY (Secondary) *Cardiac Failure*

(Signed) *C. J. Heer* M. D.
H. O. R. PATTERSON
191... (Address) *H. O. R. PATTERSON*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *—* yrs., *—* mos., *—* ds. In the State *—* yrs., *—* mos., *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Int. Aurlun Ave* DATE OF BURIAL, *March 31, 1920*

20-UNDERTAKER *Mrs. H. A. Elliott* ADDRESS *1745 - Ashland St.*

D41851

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D41851

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Arbuton Ave* ST.: *25* WARD)REGISTERED NO. _____
(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

2-FULL NAME

Ereestine Albrecht

(a) RESIDENCE. No.

Arbuton Ave Lakeland

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *28* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed,
or Divorced (write the word) *Widowed*5a If married, widowed, or divorced
HUSBAND of *Martin Albrecht*
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *March 24 1846*7 AGE Years *75* Months Days *6* If LESS than
1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*At home*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Germany*

10 NAME OF FATHER

John Ziemke

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant
(Address)*Hulda Mielke*
Arbuton Ave Lakeland

15

APR 1 - 1920

ROBERT F. FAUTER

Registrar

Burial Permit 0141

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 30 1920*

17

I HEREBY CERTIFY, That I attended deceased from
March 16, 19*20*, to *March 30*, 19*20*,
that I last saw her alive on *March 30*, 19*20*,
and that death occurred, on the date stated above, at *4 P.* m.
The CAUSE OF DEATH* was as follows:*Paralytic stroke*(duration) *no* yrs. *no* mos. *2* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *inability to move*(Signed) *Raymond O. Gorman*, M. D., 19 (Address) *Lakeland**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St Pauls Cemetery

DATE OF BURIAL

April 2 1920

20 UNDERTAKER

H. Sander Sons

ADDRESS

1700 Park

THIS IS VERY IMPORTANT. See instructions on back of certificates.

D41852

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41

D41852

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3208 Eastern Ave* ST. *26* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Henry Heber(a) RESIDENCE. NO. *3208 Eastern Ave* ST. *26* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Married</i>
----------------------	---------------------------------	--

5a If married, widowed, or divorced
HUSBAND of *Bertinde Heber*
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *April 6, 1868*

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<i>57</i>	<i>57</i>	<i>11</i>	<i>23</i>	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Engineer*(b) General nature of industry, business, or establishment in which employed (or employer) *Stationary*(c) Name of employer *National Oil Co.*9 BIRTHPLACE (city or town) *Balto*
(State or country)10 NAME OF FATHER *John Heber*11 BIRTHPLACE OF FATHER (city or town) *Balto*
(State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Katherine Heber*13 BIRTHPLACE OF MOTHER (city or town) *Germany*
(State or country)14 Informant *Bertinde Heber*
(Address) *3208 Eastern Ave*15 Filed *APR 1 - 1920* *ROBERT E. LEAUTE*
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 29 1920*17 I HEREBY CERTIFY, That I attended deceased from *Feb 28*, 19*20*, to *March 29*, 19*20*, that I last saw him alive on *March 28*, 19*20*, and that death occurred, on the date stated above, at *1:15 P.* m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency(duration) yrs. mos. *2* ds.CONTRIBUTORY *Carcinoma of Stomach*
(Secondary)(duration) yrs. *6* mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *C. K. Schneider*, M. D.19 (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn

DATE OF BURIAL

April 1 1920

20 UNDERTAKER

H. Sanders & Sons

ADDRESS

1707 E. 11th St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41853

CERTIFICATE OF DEATH

120 D41853

1-PLACE OF DEATH

CITY OF BALTIMORE (NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

41 yrs.

mos.

20 ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

1 SEX Female 2 COLOR OR RACE white 3 Single, Married, Widowed, or Divorced Married

4 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

APR 1 - 1920

ROBERT E. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY that I attended deceased from

Jan 15, 1920 to Mar 31, 1920

that I last saw him alive on Mar 27, 1920

and that death occurred, on the date stated above, at 6 9 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

Chronic Nephritis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) J. M. D.

19 (Address) 1120 W. 11th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cem April 3 1920

20 UNDERTAKER

ADDRESS

John J. Cowan & Son 200 Hollins

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41854

D41854

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1938th Lafayette ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Adelsberger

(a) RESIDENCE No. 1938th Lafayette ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 10 mos. 14 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth C. Adelsberger

6 DATE OF BIRTH (month, day, and year) May 16 1873

7 AGE

Years 46

Months 10

Days 14

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER James F. Adelsberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mr. J. C. Adelsberger 1938th Lafayette St.

15 Filed

APR 1 - 1920

ROBERT A. BLAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1920

17

I HEREBY CERTIFY, That I attended deceased from

Mar 21, 1920, to Mar 30, 1920,

that I last saw him alive on Mar 30, 1920,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry J. Jones, M. D.

, 19 (Address) 735 N. Hollen St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Bachman's

4/2/20

20 UNDERTAKER

ADDRESS

E. K. Kelly

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41855

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2137 West Lexington ST. 20 WARD)

2-FULL NAME

Belle Hooker

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE, NO. 2137 West Lexington ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 77 AGE Years Months Days 61 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co (State or country) Maryland10 NAME OF FATHER William Barney11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md12 MAIDEN NAME OF MOTHER Wynne Welsh13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)14 Informant Mrs Florence Naylor (Address) 2137 W Lexington15 APR 1 1920 ROBERT R. KAUTER RegistrarBurial Permit Class

2512 Md Ave

43

D41855

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 192017 I HEREBY CERTIFY, That I attended deceased from Mar. 1st, 1920, to April 1, 1920.that I last saw her alive on Mar. 28th, 1920;and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma(duration) 9 yrs. mos. ds.CONTRIBUTORY Arterio Capillary Fibrosis (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Bella Md If not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Consultation(Signed) Frank S. Hurdley M. D.19 (Address) 2512 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Westminster Maryland4/29 192020 UNDERTAKER William Cook

ADDRESS

50th North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41856

CERTIFICATE OF DEATH.

105

D41856

PLACE OF DEATH

CITY OF BALTIMORE (No. *Camp Holabird*)

FULL NAME *Julius Andrey*

(Residence in Baltimore: No. *Camp Holabird*)

St.: *26*

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male*

4-COLOR OR RACE, *white*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Unknown*

6-DATE OF BIRTH, *Unknown*

(Month)

(Day)

(Year)

7-AGE, *26*

6

mos. da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Soldier*

(b) General nature of industry, business, or establishment in which employed (or employer). *U.S. Army*

9-BIRTHPLACE, (State or Country), *West Texas*

10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER (State or Country), *Unknown*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Camp Holabird*

(Address)

15-APR 1 - 1920

ROBERT A. BAUTER

Bureau of Health

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *April 1, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

acute gastroenteritis

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) *Henry R. L. Lister* M. D.

April 1, 1920 (Address) *1610 E. Pratt St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *West Texas*

DATE OF BURIAL, *April 1, 1920*

20-UNDERTAKER *Max Linsen*

ADDRESS *127 E*

Baltimore

important. See instructions on back of certificate.

D41857

HEALTH DEPARTMENT—CITY OF BALTIMORE D41857

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1525 N. Stricker* ST. *15* WARD)

REGISTERED NO. C

2-FULL NAME

Mrs Louisa Hellman

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1525 N. Stricker*St.; *68* yrs., *✓* mos., *✓* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Married*

6-DATE OF BIRTH,

Jan *19*, *1837*
(Month) (Day) (Year)

7-AGE,

83 yrs., *2* mos., *10* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Retired

(b) General nature of industry, business, or establishment in which employed (or employer).

Housekeeper

9-BIRTHPLACE,

(State or Country),

Germany.

10-NAME OF FATHER,

Christian Blessing

11-BIRTHPLACE OF FATHER

(State or Country),

Germany.

12-MAIDEN NAME OF MOTHER

Fredericka Kummer

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Sophie Hermann*(Address) *1525 N. Stricker St.*

15-

APR 1 - 1920

ROBERT B. KRAUTER

Filed

191

Baltimore Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Mar *29*, *1920*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Nov 12* 191*9*, to *March 29* 19*20*, that I saw her alive on *Mar 29* 19*20*, and that death occurred, on the date stated above, at *8:30* m.

The CAUSE OF DEATH* was, as follows:

Coronary due to
Chronic Nephritis
(Duration) *3* yrs., *✓* mos., *✓* ds.

CONTRIBUTORY (Secondary)

Endocarditis

(Signed)

Geo. Shannon M. D.
Mar 29, 1920 (Address) *700 Fulton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

March 29, 1920

20-UNDERTAKER

Samuel Taylor

ADDRESS

916

841858

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D41858

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 N. Caroline ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Adelaide S. Constance*

(a) RESIDENCE. No. 1013 N. Caroline ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov. 14 - 1844*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

75 4 15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Jesse Sherwood

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Emily Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Amie C. Wheeler 1013 N. Caroline St.

15

APR 1 - 1920

ROBERT B. KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 29 1920*

17

I HEREBY CERTIFY, That I attended deceased from

1914, to *March 29, 1920.*that I last saw her alive on *March 29, 1920.*and that death occurred, on the date stated above, at *5:50 p.m.*

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Coronary (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *No*What test confirmed diagnosis? *Urine*

(Signed)

Alfred Sage M. D.

19 (Address)

709 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery Apr. 1 1920

20 UNDERTAKER

ADDRESS

Wm. C. Black 927 N. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41859

D41859

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3829 Clifton ave. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha E. Harrington(a) RESIDENCE. NO. 3829 Clifton ave. ST. 15 WARD. Erie Pa.
(Usual place of abode) (If nonresident give city or town and State)Length of residence in city or town where death occurred 9 yrs. 9 mos. ds. How long in U. S. if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) April 6-18457 AGE Years 74 Months 11 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

St. Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ontario Canada

10 NAME OF FATHER

Mr. Owen

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Wales

12 MAIDEN NAME OF MOTHER

Mary Kear

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Wales

14

Informant (Address)

J. L. Harrington
3829 Clifton ave.

15

File

APR 1-1920ROBERT A. ELAETERBurial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31/192017 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 19 19, to March 31, 19 20.that I last saw her alive on March 31, 19 20, at 10 P m.and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:Chronic interstitial nephritis, arterio-sclerosis.
(duration) 1 yrs. mos. ds.CONTRIBUTORY Chronic interstitial nephritis
(Secondary) arterio-sclerosis (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date ofWas there an autopsy? NOWhat test confirmed diagnosis? urinary analysis(Signed) W. S. Hublett M. D.
March 31/20 (Address) 3402 Clifton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Erie Penna.Apr 2 1920

20 UNDERTAKER

Mr. C. Black 927 N. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41860

CERTIFICATE OF DEATH.

40

D41860

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital

St.: 18 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Vincent Trainer

(Residence in Baltimore: No. 529 N. Carey St.

St.: 65 yrs., 10 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Widow

6-DATE OF BIRTH,

May

20

1854

(Month)

(Day)

(Year)

7-AGE,

65

10

11

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Baltimore Maryland

PARENTS.

10-NAME OF

FATHER, Henry Petzing

11-BIRTHPLACE

OF FATHER
(State or Country),

Germany

12-MAIDEN NAME
OF MOTHER

Elizabeth

13-BIRTHPLACE
OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Harry C. Bullen

(Address) 529 N. Carey St.

15-

Filed

APR 1 - 1920

ROBERT E. KRAUTER
Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Oct 1, 1919, to March 31, 1920,

that I saw him alive on March 31, 1920,

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Coronary artery disease

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

..... (Duration).....yrs.....mos.....ds.

..... (Signed)..... M. D.

3/31, 1920 (Address) 144 N. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

New Cathedral

DATE OF BURIAL.

April 3, 1920

20-UNDERTAKER

J. B. Brook

ADDRESS

1003 N. ...

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41861

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

15 yrs.

— mos.

— ds.

How long in U. S., if of foreign birth?

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

1 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced, give name of (or) WIFE of Mary Smith

6 DATE OF BIRTH (month, day, and year) June 21, 1851

7 AGE Years 68- Months 9 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Gen. Indus.

(c) Name of employer B.D. House

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Frank Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Albersheim

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant (Address) Mary Smith 1413 S Carey St

15

APR 1 - 1920

ROBERT E. LEAUTE

Burial Permit Oford

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30-20

17

I HEREBY CERTIFY, That I attended deceased from Mch 1, 1920, to Mch 30, 1920, that I last saw him alive on Mch 30, 1920, and that death occurred, on the date stated above, at 8:30 P. M. The CAUSE OF DEATH* was as follows:

Oedema of Lungs

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos. ds. Stenoplegia (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John G. Johnson, M. D. 19 (Address) 1120 W. Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL

April 3 1920

20 UNDERTAKER

ADDRESS

1003 W. Baltimore

D41862

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41862

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *817 S. Lakewood Ave* ST.: *1* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Augusta Krieger

(a) RESIDENCE. NO.

817 S. Lakewood

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *31* yrs. mos. ds. How long in U. S., if of foreign birth? *31* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

WIFE of

Charles Krieger

6 DATE OF BIRTH (month, day, and year)

Jan. 7 - 1846

7 AGE

74

Years

2

Months

26

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

John Kroschke

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

not known

14

Informant (Address)

*Amelia Sandlass
817 S. Lakewood Ave*

15

Robert F. Harrison, Registrar

APR 1 - 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar. 30 1920

17

I HEREBY CERTIFY, That I attended deceased from *From 7*, 19*20*, to *March 30, 1920*, that I last saw her alive on *March 30, 1920*, and that death occurred, on the date stated above, at *8:50 P.* m. The CAUSE OF DEATH* was as follows:*Mitral Insufficiency*(duration) yrs. *3* mos. ds.

CONTRIBUTORY (Secondary)

Chronic Endocarditis (Rheumatic)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Wm. M. Avey*, M. D.*3/31, 1920* (Address) *839 S. Ellwood Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt. Carmel Cemetery**Apr. 2 1920*

20 UNDERTAKER

Girkler & Girkler

ADDRESS

1739 E. Eager St.

D41863

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41863

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 W 28th St ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Young(a) RESIDENCE. No. 103 W 28th St ST.: 12 WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7.14 4 COLOR OR RACE aa 5 Single, Married, Widowed, or Divorced (write the word) single5a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, 10 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work no(b) General nature of industry, business, or establishment in which employed (or employer) no(c) Name of employer no9 BIRTHPLACE (city or town) 103 W 28th St (State or country) Baltimore, Md.10 NAME OF FATHER William Coleman11 BIRTHPLACE OF FATHER (city or town) no(State or country) Virginia12 MAIDEN NAME OF MOTHER Regina Young13 BIRTHPLACE OF MOTHER (city or town) no(State or country) Baltimore, Md.

14

Informant (Address) 103 W 28th St

15

APR 1 - 1920 Robert J. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31/20 1917 I HEREBY CERTIFY, That I attended deceased from March 31, 1920 to March 31, 1920, that I last saw her alive on March 31, 1920, and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH* was as follows:

premature birth and physical condition of motherCONTRIBUTORY (Secondary) condition of mother (duration) no yrs. no mos. no ds.18 Where was disease contracted if not at place of death? noDid an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? physical condition(Signed) Geo. S. Hall M. D.19 (Address) 426 E 73rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D41864

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41864

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *11*)

2-FULL NAME

(Residence in Baltimore: No. *11*)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *M.* 4-COLOR OR RACE *W.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH *April Mar 31*, 192*2*
(Month) (Day) (Year)7-AGE, *me* yrs. *me* mos. *me* ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country) *Dunkirk*PARENTS.
10-NAME OF FATHER, *"*
11-BIRTHPLACE OF FATHER (State or Country), *"*
12-MAIDEN NAME OF MOTHER, *"*
13-BIRTHPLACE OF MOTHER (State or Country), *"*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Officer H. Alder*(Address) *1010 1st St.*15- *Robert F. Harrison,*

APR 1 - 1920

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Mar 30*, 192*0*
(Month) (Day) (Year)17- I HEREBY CERTIFY, that I took charge of the remains described above, held an *Inquest* thereon and from the evidence obtained by said *Inquest* find that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Signed) *James H. Harrison* D.
Mar 31 1920 (Address) *3132 N. Hollands*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *JOHNS HOPKINS HOSPITAL* DATE OF BURIAL, *Mar 31*20-UNDERTAKER *W. C. Woodall* ADDRESS *W. C. Woodall*

important. See instructions on back of certificate.

D41865

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41865

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mug Hosp.*ST.: *21*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *James F. Fullin*(a) RESIDENCE. No. *1087 W. Pratt*

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. *10*mos. *17*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 14, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*10**17*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

John F. Fullin

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Minnie R. Fullin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa.

14

Informant (Address)

John F. Fullin 787 W. Pratt St.

APR 1 - 1920

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

3/31 1920

17

I HEREBY CERTIFY, That I attended deceased from

3/31 1920 to 3/31 1920

that I last saw him alive on

3/31 1920

and that death occurred, on the date stated above, at

12 m.

The CAUSE OF DEATH* was as follows:

Intussusception - violent, acute.

(duration)

yrs.

mos.

4 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Yes Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Edward D. Ridgely

M. D.

19 (Address)

Mug Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Woodlawn Cemetery**April 2 1920*

20 UNDERTAKER

*W M Routsom**230 N. Green*

D41866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41866

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. St. Agnes Hospital)

ST.

WARD)

2-FULL NAME Emmerson League(Residence in Baltimore: No. 617 W. Barre St.)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Life
St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,
Male4-COLOR OR RACE,
White5-SINGLE,
MARRIED, Widower
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Apr. 22, 1847
(Month) (Day) (Year)

7-AGE,

72 yrs. 11 mos. 9 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Candy Mfg.Retired

9-BIRTHPLACE,

(State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER,

Marcella League

11-BIRTHPLACE OF FATHER

(State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER

Julia Dougherty

13-BIRTHPLACE OF MOTHER

(State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt. C. Sunstrom(Address) 617 W. Barre St.

15-

APR 1 - 1920

Robert P. Harrison,

101.....

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 30, 1920, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquiry.....
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....
(Inquest, au-Inquiry.....find that said deceased came to his death
(topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by an Automobile.....Fracture of the base of the.....Skull.....Accidental.....

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) F. E. Davis..... M. D.

(Coroner.)

..... 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

London Park Cemetery

DATE OF BURIAL,

April 2 1920

20-UNDERTAKER

W. M. Routhon

ADDRESS

230 S. Bruce

Important. See instructions on back of certificate.

D41867

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41867

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1101 Sharp*ST.: *23* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Albert R. Lang*(a) RESIDENCE. NO. *1101 Sharp*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

1 yrs. 5 mos.

ds. How long in U. S., if of foreign birth?

yrs. *2 1/2* mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Mar 11 1918*

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

*1**5*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*10 NAME OF FATHER *John Lang*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Mary Jacob*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

John Lang
1101 Sharp

15

APR 1 - 1920

Robert F. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 31 1920*

17

HEREBY CERTIFY, That I attended deceased from *Mar 26 1920* to *Mar 31 1920*.that I last saw him alive on *Mar 31 1920*.and that death occurred, on the date stated above, at *10 a. m.*

The CAUSE OF DEATH* was as follows:

Bronchitis(duration) yrs. mos. *10* ds.

CONTRIBUTORY (Secondary)

Broncho pneumonia(duration) yrs. mos. *5* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical Exam*(Signed) *J. H. Thomas* M. D.Address *1228 N. Caroline*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Cross Cemetery, A. D.**April 1920*

20 UNDERTAKER

ADDRESS

Mr. J. E. Loman 1428 N. Charles

D41868

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41868

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 540 Bentala ST.; 70 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Schreyer(Residence in Baltimore: No. 540 Bentala St St.; 55 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 26, 1848
(Month) (Day) (Year)

7-AGE, 72 yrs. 3 mos. ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, house
(b) General nature of industry, business, or establishment in which employed (or employer), 03

9-BIRTHPLACE, (State or Country), Germany

PARENTS.
10-NAME OF FATHER, Henry Enoch
11-BIRTHPLACE OF FATHER (State or Country), Germany
12-MAIDEN NAME OF MOTHER, Louise Bloes
13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Heriberto Schneider(Address) 540 Bentala St

15-

Robert P. Harrison,

191

APR 1 - 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 23, 1920, to March 29, 1920, that I saw her alive on March 29, 1920, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia
hypertension
atherosclerosis
(Duration) 10 days

CONTRIBUTORY (Secondary)

(Duration) 10 days
(Signed) W. H. Harrison M. D.
731, 1920 (Address) 2151 Fulton St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New CathedralApril 2, 1920

20-UNDERTAKER

ADDRESS

George A. Schmat 1301 E. Pratt Ave

D41869

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D41869

PLACE OF DEATH

CITY OF BALTIMORE (No. 522 S Becker St.)

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 622 S Becker

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *Ch* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Mar*

6-DATE OF BIRTH,

Feb 7, 1920
(Month) (Day) (Year)

7-AGE,

1 mos. 24 ds.

If LESS than 1 day,
hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None
None

9-BIRTHPLACE, (State or Country),

Balto.

10-NAME OF FATHER,

Stanley Borzal

11-BIRTHPLACE OF FATHER (State or Country),

Austria

12-MAIDEN NAME OF MOTHER

Catherine Pienkowsky

13-BIRTHPLACE OF MOTHER (State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Stanley Borzal

(Address)

522 S. Becker St.

15-

Robert F. Harrison,

191.

Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

April 1, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained or said

(Inquest, au-

opsy or inquiry) find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

4-1-20 (Address) *St. El...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Holy Rosary Cem.

April 2, 1920

20-UNDERTAKER

ADDRESS

Wm Fialkowski

1618 Eastern Ave

important. See instructions on back of certificate.

APR 1 - 1920

D41870

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41870

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Municipal Tuberculosis Hospital
CITY OF BALTIMORE: (No. ST.: WARD)

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

2-FULL NAME Edwin Bodine

(a) RESIDENCE. No. 515 16th street
(Usual place of abode)

ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed,
or Divorced (write the word) Widowed5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE Years Months Days If LESS than
1 day, hrs. or min.
35

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work Laborer 040(b) General nature of industry,
business, or establishment in
which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER William Bodine

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Barbara Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania14 Informant Hospital Records
(Address) M.T.H.15 Filed Robert B. Harrison,
Registrar

APR 1 - 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1920

17 I HEREBY CERTIFY, That I attended deceased from
March 24, 1920, to April 1st, 1920,
that I last saw him alive on March 31st, 1920,
and that death occurred, on the date stated above, at 7.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed) J. R. Wilbur, M. D.

4-1-20 (Address) Municipal Tuberculosis Hosp

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Lawn Cem

Apr 4 1920
ADDRESS

20 UNDERTAKER

John Beltrick

2008 Beltrick

D41871

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓ D41871

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3022 M^c Eldery, ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE, No. 3022 M^c Eldery, ST. 7 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10-1899

7 AGE Years 20 Months 11 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

10 NAME OF FATHER John D. Borcharding

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Minnie Hahn

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14

Informant (Address)

John D. Borcharding 3022 M^c Eldery

ROBERT I. ...

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1920

17 I HEREBY CERTIFY, That I attended deceased from 3/10, 1920, to 3/30, 1920,

that I last saw him alive on 3/29, 1920,

and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Pulmonia)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

3/21/20 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Balto Cemetery

Apr 2 1920

20 UNDERTAKER

ADDRESS

John ...

218 ...

APR 1 - 1920

D41872

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41872

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14-E-25th ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Carrie Virginia DuBREVIL

(a) RESIDENCE. NO.

14-E-25thST. 12 WARD.Resident

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? 59 yrs. 6 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

George A. Du Breuil6 DATE OF BIRTH (month, day, and year) Sept 17/18617 AGE Years Months Days If LESS than 1 day, hrs. or min. 59 6 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Jacob Kraft

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Alsea Lomaine France

12 MAIDEN NAME OF MOTHER

Christine Waller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Maryland

PARENTS

14 Informant Max-Alex J. Du Breuil (daughter) (Address) 14-E-25th Street

15

Robert P. Harrison, Registrar

APR 1 - 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 192017 I HEREBY CERTIFY, That I attended deceased from March 25, 1920, to March 31, 1920, that I last saw h^e alive on March 28, 1920, and that death occurred, on the date stated above, at 1 P.M. The CAUSE OF DEATH* was as follows:Broncho Pneumonia(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

at place of deathDid an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? Physician's(Signed) Charles F. Hie M. D., 19 (Address) Wylie at 8th Baltimore Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Green Mount CemeteryApril 3 1920

20 UNDERTAKER

STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

D41873

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41873

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE:

ST.:

WARD)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 71 yrs. 10 mos. 24 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Emma H. Hasfield

6 DATE OF BIRTH (month, day, and year) May-7-1848

7 AGE Years 71 Months 10 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer)

Capitalist

(c) Name of employer

(Self.)

9 BIRTHPLACE (city or town) (State or country)

Howard Co. Maryland

10 NAME OF FATHER

Albert G. Hasfield

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Howard Co. Maryland

12 MAIDEN NAME OF MOTHER

Margaret G. Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Howard Co. Maryland

PARENTS

14 Informant (Address)

Edwin Hasfield Jr. (Son) 1223 Linden Ave

Robert F. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 1914 to March 1920,

that I last saw him alive on March 31 1920,

and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis

CONTRIBUTORY (Secondary) Arterio Sclerosis + Myocarditis (duration) 6 yrs. 6 mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

STEWART & MOWEN COMPANY

(WILLIAM F. WOODEN, Secretary)

ADDRESS

108 W. NORTH AVE.

APR 1 - 1920

Burial Permit Clerk

D41874

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D41874

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 523 Madison

ST. 10

WARD)

REGISTERED No. C

2-FULL NAME

William Hsie

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 523 Madison

St. 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Don't know

6-DATE OF BIRTH,

April 1, 1901

(Month) (Day) (Year)

7-AGE,

76

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Stone cutter

9-BIRTHPLACE, (State or Country),

Scotland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Robert P. Harrison

(Address)

Fullerton

15-

Robert P. Harrison,

191

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 30, 1940

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner)

Address

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

1920

20-UNDERTAKER

ADDRESS

11th St. 502 E. N. B. A.

important. See instructions on back of certificate.

D41875

HEALTH DEPARTMENT--CITY OF BALTIMORE

D41875

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Robert M. Harrison,

Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed)

191 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

APR 1-1920

D41876

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41876

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST.: *5* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *James Patterson*(a) RESIDENCE. NO. *1106 Green Street* ST.: *12* WARD. *16*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Margaret Patterson* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *Sept 2 1868*7 AGE *51* Years Months *6* Days *29* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer 140*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Maryland* (State or country)10 NAME OF FATHER *Tony Patterson*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *Hospital Registrar* (Address)15 *Robert F. Harrison,* Registrar

APR 1 - 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 31 1920*17 I HEREBY CERTIFY, That I attended deceased from *March 29*, 1920, to *March 31*, 1920, that I last saw him alive on *March 31*, 1920, and that death occurred, on the date stated above, at *5:40* p. m.

The CAUSE OF DEATH* was as follows:

Emphysema, Lethargia

(duration) yrs. mos. ds.

CONTRIBUTORY *Also Emphysema* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted *City* If not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Dr. W. R. Ruff* M. D., 19 (Address) *Dr. H. H. Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery April 3 1920

20 UNDERTAKER

Wm. C. Miller ADDRESS *2334 Jefferson*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41873

CERTIFICATE OF DEATH.

91/✓ D41873

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *115 Hughes*

ST.;

WARD) *22*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Albert Clarke*(Residence in Baltimore: No. *115 Hughes St.*

St.;

yrs.,

mos.,

da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Male</i>	4-COLOR OR RACE. <i>Colored</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <i>Single</i>
6-DATE OF BIRTH, <i>July</i> <i>23</i> <i>1912</i> (Month) (Day) (Year)		
7-AGE, <i>8</i> <i>8</i> <i>8</i> yrs. mos. da.		If LESS than 1 day,hrs. or.....min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work..... <i>None</i> (b) General nature of industry, business, or establishment in which employed (or employer).....		

9-BIRTHPLACE,
(State or Country), *Baltimore*

PARENTS.	10-NAME OF FATHER, <i>Wash Clarke</i>
	11-BIRTHPLACE OF FATHER (State or Country), <i>Va</i>
	12-MAIDEN NAME OF MOTHER <i>Helia Johnson</i>
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Washington D.C.</i>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Helia Johnson*(Address) *115 Hughes St.*15-*APR 2 - 1920*

ROBERT E. KRAUTH

BALTIMORE CITY CLERK

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Mar 31, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Mar 29, 1920, to Mar 31, 1920,*that I saw him alive on *Mar 29, 1920,*and that death occurred, on the date stated above, at *5:30 AM.*

The CAUSE OF DEATH* was as follows:

Brucella bacteremia(Duration).....yrs.....mos.....*4*.....da.CONTRIBUTORY
(Secondary)(Duration).....yrs.....mos.....*20*.....da.(Signed).....*J. E. ...*.....M. D.*3/31, 1920* (Address) *14 E. ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the.....yrs.....mos.....da. State.....

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

St. Auburn

DATE OF BURIAL,

Apr 2, 1920

20-UNDERTAKER

J. H. Brown & Son

ADDRESS

108 W. Mount

D41878

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *153-5* St. *21* WARD)2-FULL NAME *John Mahoney*(Residence in Baltimore: No. *153-5* Ward *21*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *53* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

Black
*Wool*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH

1
(Month) (Day) (Year)

7-AGE

35 yrs. mos. ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Lab.*

9-BIRTHPLACE

(State or Country),

Balt. Md

10-NAME OF FATHER

John Mahoney

11-BIRTHPLACE OF FATHER

(State or Country),

Balt. Md

12-MAIDEN NAME OF MOTHER

X

13-BIRTHPLACE OF MOTHER

(State or Country),

X

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Mahoney*(Address) *602 Archer*

15-

APR 2 - 1920

ROBERT E. KRAUTER

Filed *191* Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

March 30, 19*20*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

*Multiple lacerations caused by a suddenly falling from auto work and while passing over a*CONTRIBUTORY *Shock (hemorrhage)* (Secondary)

(Duration) yrs. mos. ds.

(Signed) *D. J. [Signature]* M. D.

(Coroner.)

March 31, 1920 (Address) *1459 Bond*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *San Jose* in the of death *1* yrs. mos. ds. State *1* yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt. Auburn

DATE OF BURIAL

4-2, 1920

20-UNDERTAKER

John J. Treadwell

ADDRESS

142 W. Hill St

important. See instructions on back of certificate.

Kolt
HEALTH DEPARTMENT—CITY OF BALTIMORE

D41879

CERTIFICATE OF DEATH.

126 ✓ D41879

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2419 McElderry St. 7

ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2419 McElderry St.

St.: 70 yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH,

Oct 23, 1836
(Month) (Day) (Year)

7-AGE,

83 yrs. 5 mos. 7 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Retired 30 yrs.
Milk Hairy9-BIRTHPLACE,
(State or Country),

Germany

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER
(State or Country),

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Kolt

(Address) 2419 McElderry St.

15-

APR 2 - 1920

ROBERT B. KAUTER

Filed

191

Baltimore City Health Department

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 30, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 23, 1920, to March 30, 1920,

that I saw him alive on March 30, 1920,

and that death occurred, on the date stated above, at 9:45 p.m.

The CAUSE OF DEATH* was as follows:

Prostatitis - Chronic

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Similar (Chronic Prostatitis)

(Duration) 1 yrs. mos. ds.

(Signed) W. J. Gerry M. D.

March 31, 1920. (Address) 677 - 17th St. N.W.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Pauls

DATE OF BURIAL,

4-2-1920

20-UNDERTAKER

H. Sander & Sons 1707 1st St.

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41880

CERTIFICATE OF DEATH.

34 ✓ D41880

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1017 Calhoun* ST. *16* WARD)

2-FULL NAME

Beatrice Elizabeth Sembly

(a) RESIDENCE. NO.

1017 Calhoun ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. *11* mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

*C*5 Single, Married, Widowed,
or Divorced (write the word)*Infant.*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Infant*

6 DATE OF BIRTH (month, day, and year)

May 10 1919

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*11*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Infant.*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*1116 Calhoun St.
Baltimore Md.*

10 NAME OF FATHER

*Vernon Sembly.*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Baltimore*

12 MAIDEN NAME OF MOTHER

*Edith Isabel Ennis*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*St Marys Co.
Md.*

14

Informant
(Address)*Vernon Sembly
1017 Calhoun St.*

15

Filed
*APR 2 - 1920**ROBERT E. ELLAUER*
Registrar
Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 1 1920

17

I HEREBY CERTIFY, That I attended deceased from
March 16, 19*20*, to *April 1*, 19*20*,that I last saw her alive on *March 30*, 19*20*,and that death occurred, on the date stated above, at *11 A.* m.

The CAUSE OF DEATH* was as follows:

Cervical Adenitis Tubercular

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Rickets*(duration) yrs. *6* mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *W. H. Wright*, M. D.*4/1, 1920* (Address) *1209 Presatman**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt Auburn**Apr 2nd 1920*

20 UNDERTAKER

ADDRESS

*Samuel W. Chase-son**1400. Asher*

D41881

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41881

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Vincent ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Stewart

(a) RESIDENCE. No.

1118 Vincent

ST.

WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

4 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

1/2 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Irene Stewart

6 DATE OF BIRTH (month, day, and year)

Sept. 2 1877

7 AGE

Years

42

Months

6

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Furniture

(b) General nature of industry, business, or establishment in which employed (or employer)

Moving

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md. West River

10 NAME OF FATHER

Richard Stewart

11 BIRTHPLACE OF FATHER (city or town)

West River

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Florence Stewart

13 BIRTHPLACE OF MOTHER (city or town)

West River

(State or country)

Md.

14

Informant

Arline Stewart

(Address)

1118 Vincent St

15

APR 2 - 1920

ROBERT J. LEVY

Facial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mar 30

19

17

I HEREBY CERTIFY, That I attended deceased from

Feb 15, 1920, to Mar 30, 1920.

that I last saw him alive on

Mar 30, 1920.

and that death occurred, on the date stated above, at

6:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs.

4 mos.

ds.

CONTRIBUTORY (Secondary)

Valvular Heart Disease

(duration) yrs.

2 mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis: Examination of urine

(Signed)

E. W. F. M. D.3/30, 1920 Address 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

MtMt AuburnApr 2/20

20 UNDERTAKER

ADDRESS

Edw Ringgold 1467 Cary

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41882

CERTIFICATE OF DEATH.

REGISTERED NO.

D41882

PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.; *4* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Louis Bruce*(a) RESIDENCE. NO. *7 Mile Lane, Pikesville* ST., *Pikesville Md.* WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

mos. *3* ds.

How long in U. S., if of foreign birth?

mos. *18* ds.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1896*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *H. Bruce*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*12 MAIDEN NAME OF MOTHER *E. Thompson*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

14

Informant (Address) *University Hosp. Data Green + Lombard*

15

FILE

APR 2 - 1920

ROBERT E. KAUFER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 31 1920*

17

I HEREBY CERTIFY, That I attended deceased from *Mar 28*, 19*20*, to *Mar 31*, 19*20*.that I last saw him alive on *Mar 30*, 19*20*.and that death occurred, on the date stated above, at *2:00 a.m.*

The CAUSE OF DEATH* was as follows:

General Peritonitis following Ruptured Appendix(duration) yrs. mos. *5* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *yes* Date of *3/29/20*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *C. H. Schaefer*

M. D.

, 19

(Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Union Baptist Center**Apr 2/20*

20 UNDERTAKER

ADDRESS

*Edw. Ringgold**1463 Carey*

D41883

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D41883

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1812 Thomas Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Walter Bridgely Jones(Residence in Baltimore: No. 1812 Thomas Ave St. 33 yrs. 6 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

September 14, 1886
(Month) (Day) (Year)

7 AGE

33 yrs. 6 mos. 14 ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Clerk

9 BIRTHPLACE (State or country)

Baltimore

10 NAME OF FATHER

Hamilton Jones

11 BIRTHPLACE OF FATHER (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Browning

13 BIRTHPLACE OF MOTHER (State or country)

Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alice S. Parkhurst

(Address)

1410 Park Ave

15

APR 2 - 1920

ROBERT E. RAUTER

Baptist Church

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 31, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 8th, 1920, to March 31, 1920.that I saw him alive on March 31st, 1920.and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Emphysema
& Chronic Valvular HeartDisease (Duration) yrs. mos. ds.

Contributory (SECONDARY)

Lobar Pneumonia

(Duration) yrs. mos. ds.

(Signed),

Alice S. Parkhurst, M.D.Mar 31, 1920 (Address) 1410 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

4/2, 1920

20 UNDERTAKER

Philp HenryADDRESS 3016Orleans

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

D41884

Strouse
HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

120 D41884

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1530 N. Strick* ST.; *15* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1530 N. Strick* St.; *40* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, *Widow* OR DIVORCED. (Write the word.)

6-DATE OF BIRTH, *Not known*, *1889*
(Month) (Day) (Year)

7-AGE, *61* yrs., mos. ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Not known*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Va.*

PARENTS.
10-NAME OF FATHER, *Not known*
11-BIRTHPLACE OF FATHER (State or Country), *Not known*
12-MAIDEN NAME OF MOTHER, *Not known*
13-BIRTHPLACE OF MOTHER (State or Country), *Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Kehler Schmidt*(Address) *1530 N. Strick St.*

15-

Filed. **APR 2 - 1920** **ROBERT E. BRAUTER**
Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Mar. 31*, *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Mar. 20*, *1920*, to *Mar. 31*, *1920*, that I saw her alive on *Mar. 31*, *1920*, and that death occurred, on the date stated above, at *6:10 P. m.*

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis at last
(Duration) *1* yrs., mos. ds.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs., mos. ds.

(Signed) *Chas. L. McCarthy* M. D.

Apr. 1, *1920* (Address) *906 N. Strick St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, *1* yrs., mos. ds. In the State, *1* yrs., mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Woodlawn Cem.* DATE OF BURIAL, *April 2, 1920*

20-UNDERTAKER, *W. J. Fickner* ADDRESS, *North Pen*

D41885

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41885

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 Mill Race Road WARD 3)2-FULL NAME Lona M. Talbott3-RESIDENCE. No. 1504 Mill Race Road WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 19, 19207 AGE Years Months Days If LESS than 1 day, hrs. or min. 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER Charles Talbott11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore12 MAIDEN NAME OF MOTHER Lona Walker13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore14 Informant (Address) Charles Talbott
Mill Race Road

15 F. APR 2 - 1920 ROBERT A. KRAUTER Registrar

Burial Permit Obtained

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 19, 1920, to March 30, 1920.that I last saw him alive on March 29, 1920.and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Ca gen. tel. atelectasis.(duration) yrs. mos. ds. 10

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓Did an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? roux(Signed) B. E. French, M. D.Address 1527 Union Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mary's, Hampden April 2, 1920

20 UNDERTAKER

ADDRESS

Chenoweth Son Chestnut

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41886

CERTIFICATE OF DEATH.

120 D41886

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3500 Bank ST.: 26 WARD)2-FULL NAME James F. Oliver(a) RESIDENCE. No. 3500 Bank ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Oliver6 DATE OF BIRTH (month, day, and year) May 12 18497 AGE Years 70 Months 10 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horseshoer(b) General nature of industry, business, or establishment in which employed (or employer) 036

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland10 NAME OF FATHER George Oliver11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)12 MAIDEN NAME OF MOTHER Mary E. Cunningham13 BIRTHPLACE OF MOTHER (city or town) Scotland (State or country)14 Informant William S. Oliver (Address) 3500 Bank St15 APR 2 - 1920 ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 192017 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1920, to March 30, 1920, that I last saw him alive on March 30, 1920, and that death occurred, on the date stated above, at 355 P. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease
Incurable (duration) yrs. mos. ds.CONTRIBUTORY (Secondary) Incurable (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) H. H. H. H. H. M. D.19 (Address) 2927 St Paul Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Oak Lawn April 3 1920

20 UNDERTAKER ADDRESS

H. Lander Bros 1710 Paul St

TION is very important. See instructions on back of certificates.

D41887

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41887

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Aged Women, Home, 19*

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary J. Mc Keldin*(Residence in Baltimore: No. *1400 N. Lexington*St.; *So.* yrs., *2* mos., *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX *Female*4-COLOR OR RACE, *Wt.*5-SINGLE, *Wid*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *Jan 6*, *1870*

(Month)

(Day)

(Year)

7-AGE *50* yrs., *2* mos., *0* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *None*(b) General nature of industry, business, or establishment in which employed (or employer) *Wid*

9-BIRTHPLACE,

(State or Country), *Balto. Md.*10-NAME OF FATHER, *John Baldwin*11-BIRTHPLACE OF FATHER *Baden, Baden*
(State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Frances C. Kelley*13-BIRTHPLACE OF MOTHER *Baltimore Md.*
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ellen J. Jones*(Address) *Matron*

15-

APR 2 - 1920

Filed

191

ROBERT B. ERAUTER

Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 1*, *1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Mar 15* 191*2*, to *April 1* 191*2*,that I saw him alive on *Mar 31* 191*2*,and that death occurred, on the date stated above, at *2:30* p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration)....yrs. *1* mos.ds.CONTRIBUTORY (Secondary) *Arterio-Sclerosis*

(Duration)....yrs.mos.ds.

(Signed) *J. H. Woodward* M. D.*April 1*, 191*2*. (Address) *939 N. Fayette*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *10* yrs.mos.ds. In the Stateyrs.mos.ds.Where was disease contracted, if not at place of death? *at the home*

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Elv's Cemetery*DATE OF BURIAL, *March 3*, 191*2*20-UNDERTAKER *George J. Smith*ADDRESS *1000 N. Fayette*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41888

37 D41888

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Johns Hopkins Hospital*
 CITY OF BALTIMORE: (No. *North Broadway* ST.; *19* WARD)
 2-FULL NAME *Bozo Perich*
 (Residence in Baltimore: No. *North and Carey Street* St.; *15* yrs., mos. ds.)
1300 N. Pratt St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-SINGLE, *single*
 MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
 6-DATE OF BIRTH, *Jan 6*, 1888
 (Month) (Day) (Year)
 7-AGE, *32* yrs., *2* mos., *26* ds. If LESS than 1 day, ...hrs. or...min.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work, *Laborer 140*
 (b) General nature of industry, business, or establishment in which employed (or employer), *dish washer hotel*

9-BIRTHPLACE, (State or Country),

Serbia

10-NAME OF FATHER, *Roder Perich*
 11-BIRTHPLACE OF FATHER (State or Country), *Serbia*
 12-MAIDEN NAME OF MOTHER, *Sophia Mikosavljevic*
 13-BIRTHPLACE OF MOTHER (State or Country), *Serbia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Johns Hopkins Hospital Records*
 (Address) *North Broadway Baltimore*

15-APR 2 - 1920

ROBERT E. KRAUTER

Filed..... 191... *Robert E. Krauter*
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 1*, 1920
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *March 31* 1920, to *Apr 1* 1920, that I saw him alive on *Apr 1* 1920, and that death occurred, on the date stated above, at *1:05* p.m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency
Syphilis - duration indefinite

(Duration) *5* yrs. mos. ds.CONTRIBUTORY *Myocardial insufficiency*
(Secondary)(Duration) *10* yrs. mos. ds.(Signed) *Augusta Batten* M. D.

Apr 2, 1920 (Address) *Johns Hopkins Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *1* ds. In the State yrs. mos. ds.

Where was disease contracted, *not known*
 if not at place of death?

Former or usual residence *No permanent residence*

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL,

April 2, 1920

20-UNDERTAKER

John J. Fields 1200 W. Lombard

ADDRESS

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D41889

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

40

D41889

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15 APR 2 - 1920

Filed

191

ROBERT I KRAUTER

BURIAL FORM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Carcinoma liver (primary)
Mitral stenosis aortic

(Duration) yrs. 6 mos. ds

Contributory Cardiac dilatation

(SECONDARY) (Duration) yrs. 11 mos. ds

(Signed) F. H. Nichols M. D.

April 1, 1920 (Address) 904 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

D41890

CERTIFICATE OF DEATH

D41890

1 PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Elizabeth Home*)

2 FULL NAME

(Residence in Baltimore: No. *George Philips*)

REGISTERED NO. C

ST. *9* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. *7* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *black* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH *August 31, 1919*
(Month) (Day) (Year)

7 AGE *7* yrs. *7* mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Balt. Md*

10 NAME OF FATHER *Anthony Hard*

11 BIRTHPLACE OF FATHER (State or country) *Georgia*

12 MAIDEN NAME OF MOTHER *Lidia Philips*

13 BIRTHPLACE OF MOTHER (State or country) *Balt. Md*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W. M. M. Leonard*

(Address) *St. Elizabeth Home*

15. APR 2 - 1920 ROBERT E. KRAUTER

Filed *April 1, 1920* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *March 31, 1920*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *March 30, 1920*, to *March 31, 1920*, that I saw him alive on *March 31, 1920*, and that death occurred, on the date stated above, at *11:00* m. The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. *7* ds

Contributory (SECONDARY) *Coryza*

(Duration) yrs. mos. *3* ds.

(Signed) *Frank J. Ayer* M. D. *April 1, 1920* (Address) *2065 E. Monument St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Cathedral

DATE OF BURIAL

Apr. 2, 1920

20 UNDERTAKER

Chas. Holland

ADDRESS

1631 Belmont Hall

an

D41891

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 D41891

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

918 Ramsey St. 21

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Hilbert H. Spiker

(a) RESIDENCE. No.

918 Ramsey St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

18 hrs. mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

4-1-20

7 AGE

Years

Months

Days

If LESS than 1 day 18 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto city

10 NAME OF FATHER

David spiker

11 BIRTHPLACE OF FATHER (city or town) (State or country)

md.

12 MAIDEN NAME OF MOTHER

Rella. Durst

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

md.

14

Informant (Address)

David spiker 918 Ramsey St.

15

APR 2 - 1920

ROBERT E. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-2-1920

17

I HEREBY CERTIFY, That I attended deceased from 4-1-1920, to 4-1-1920,

that I last saw him alive on 4-1-1920,

and that death occurred, on the date stated above, at 1 9 m.

The CAUSE OF DEATH* was as follows:

Failure of respiratory orale to function etc

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Marys Hospital 4/3/20

20 UNDERTAKER

J. Walter Davis

ADDRESS

3307 Paul

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41892

CERTIFICATE OF DEATH.

80 D41892

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-STATUS.

MARRIED.

WIDOWED.

OR DIVORCED.

(Write the word.)

Married

6-DATE OF BIRTH.

July 4th, 1884
(Month) (Day) (Year)

7-AGE.

78 yrs. 7 mos. 28 ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Real Estate Broker D86

9-BIRTHPLACE.
(State or Country).

Easton Mass

PARENTS.

10-NAME OF FATHER.

Samuel Rowell Sargeant

11-BIRTHPLACE OF FATHER
(State or Country).

Vermont

12-MAIDEN NAME OF MOTHER

Loraine Sheldon

13-BIRTHPLACE OF MOTHER
(State or Country).

Mass

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

C. A. Bruneau Chiffelle

(Address).

517 Cathedral St.

15- APR 2 - 1920

ROBERT A. KRAUTER

Filed..... 191

BRIAL FIRM: J. J. J.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

March 31, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 6th 1920, to March 31st 1920,that I saw him alive on March 29th 1920,

and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration)..... yrs. 3 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed)

C. B. Bruneau Jr.

M. D.

191... (Address) 2622 Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Greenmount

DATE OF BURIAL.

4-3, 1920.

20-UNDERTAKER

Henry W. Jenkins & Sons Co

ADDRESS

M. J. Gullotti & Sons

D41894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D41894
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1914 Eutaw Place; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1914 Eutaw Place St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH,

May 19, 1892
(Month) (Day) (Year)

7-AGE,

27 yrs. 10 mos. 12 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

not avail
invalid

9-BIRTHPLACE, (State or Country),

Wash. D.C.

10-NAME OF FATHER,

Wm H. Slye

11-BIRTHPLACE OF FATHER (State or Country),

Charles E. Mld

12-MAIDEN NAME OF MOTHER

Mary Majonnie

13-BIRTHPLACE OF MOTHER (State or Country),

New Orleans La

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary M. Slye

(Address) 1914 Eutaw Place

15-APR 2 - 1920

ROBERT E. KAUTER

Filed..... 191.....

Burial Form No. 11091

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 1, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 1920, to April 1, 1920,

that I saw him alive on April 1, 1920,

and that death occurred, on the date stated above, at 1:20 p.m.

The CAUSE OF DEATH* was as follows:

Pleurisy with Effusion

(Duration)..... yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. 4 mos. ds.

(Signed) W. L. C. Jones

7/2/20, 101... (Address) Wilmington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Gruid Ridge

DATE OF BURIAL,

Apr. 2, 1920

20-UNDERTAKER

J. O. Mitchell

ADDRESS

1201 N. Fayette St.

D41895 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D41895
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent Ave.* ST.; *14* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Stella Martin*(Residence in Baltimore: No. *1401 Division St.* St.; — yrs., *2* mos. *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, *Single*
Married
Widowed
Or divorced
(Write the word.)6-DATE OF BIRTH, *Jan. 23*, 1920.
(Month) (Day) (Year)7-AGE, *2* yrs., *2* mos., *23* ds. If LESS than 1 day,
....hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... *None*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Balto. Md.*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Unknown*12-MAIDEN NAME OF MOTHER *Stella Martin*13-BIRTHPLACE OF MOTHER (State or Country), *United States*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent Ave. Balto.*(Address) *1401 Division St.*15- APR 2 - 1920
Filed..... 191. ROBERT E. KAUTER
Bacial Permit *8498*

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH, *March 31*, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan. 23*, 1920, to *Mar. 31*, 1920., that I saw her alive on *Mar. 31*, 1920., and that death occurred, on the date stated above, at *8 A.M.* The CAUSE OF DEATH* was as follows:*Malnutrition*
(Duration)..... yrs. *2* mos. ds.

CONTRIBUTORY (Secondary).....

(Duration)..... yrs. mos. ds.

(Signed) *Chas. J. Martin* M. D......, 101... (Address) *1504 McCall*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cathedral Cem. *April 2*, 1920.

20-UNDERTAKER ADDRESS

Martin & Sons *1827 W. North Ave.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41896

CERTIFICATE OF DEATH.

151

D41896

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 Keldon Ave. ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 1309 Keldon Ave. ST. 13 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 23-19207 AGE Years Months Days If LESS than 1 day, hrs. or min. 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Maryland (State or country)10 NAME OF FATHER John L. Evans11 BIRTHPLACE OF FATHER (city or town) Raynesboro Pa. (State or country)12 MAIDEN NAME OF MOTHER Flourence J. Redding13 BIRTHPLACE OF MOTHER (city or town) Pa. (State or country)14 Informant John L. Evans (Address) 1309 Keldon Ave.15 Filed APR 2 - 1920 ROBERT F. LEAUTEY Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 192017 I HEREBY CERTIFY, That I attended deceased from March 23, 1920, to April 2, 1920, that I last saw him alive on April 21, 1920, and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

MalnutritionCONTRIBUTORY (Secondary) Prematurity (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Martin M. D., 19 (Address) 4119 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Mary's Hampden April 2 1920

20 UNDERTAKER ADDRESS

Horace Burgeon 363 Hall Rd.

TION IS VERY IMPORTANT. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41899

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1435 E. Monument* ST.; *5* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1435 E. Monument* St.; *10* yrs., *10* mos. *10* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*6-DATE OF BIRTH, *Unknown*, 1 *1* (Month) (Day) (Year)7-AGE, *10* yrs., *10* mos., *10* ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer) *none*9-BIRTHPLACE, (State or Country), *Baltimore Md*10-NAME OF FATHER, *Edward Newson*11-BIRTHPLACE OF FATHER (State or Country), *N Carolina*12-MAIDEN NAME OF MOTHER, *Martha Hill*13-BIRTHPLACE OF MOTHER (State or Country), *N Carolina*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edward Newson*(Address) *1435 E Monument*

15-ROBERT E. EHAUTER

APR 2 - 1920
Filed *APR 2 - 1920* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 1*, 19*20*.
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *March 29 1920*, to *April 1 1920*, that I saw her alive on *April 1 1920*, and that death occurred, on the date stated above, at *7:35 P.m.*
The CAUSE OF DEATH* was as follows:*Broncho Pneumonia*(Duration) *4* yrs., *7* mos., *4* ds.CONTRIBUTORY *Broncho Pneumonia*
(Secondary)(Duration) *3* yrs., *7* mos., *3* ds.(Signed) *W. H. Henderson* M. D.*April 2, 1920* (Address) *708 E. Monument St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *10* yrs., *10* mos., *10* ds. In the State *10* yrs., *10* mos., *10* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Laurel*DATE OF BURIAL, *April 3, 1920*20-UNDERTAKER, *John W. Henderson & Monument*ADDRESS *1802*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D41898

D41898
1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Johnson

ST. 2nd WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Carr Donnelly

(a) RESIDENCE. NO. 1704 Johnson

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 6 mos. 17 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 13 98

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

21

6

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Mechanic 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Curtis Bay Coffee Works

9 BIRTHPLACE (city or town) (State or country)

Baltimore city

10 NAME OF FATHER

Bartholomew Donnelly

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Wrightsville Pa

12 MAIDEN NAME OF MOTHER

Mrs M. Carr

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

14

Informant (Address)

Mr Bartholomew Donnelly 1704 Johnson St.

15

APR 3 - 1920

ROBERT T. KAUFER

Burial Permit 01577

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4. 2 1920

17

I HEREBY CERTIFY, That I attended deceased from

12. 24, 1919, to 4. 2, 1920,

that I last saw him alive on 4. 2, 1920,

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary)

Pulmonary Hemorrhage

(duration) yrs. 6 mos. 6 ds.

18 Where was disease contracted if not at place of death?

Not Known

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Health Dept Exam

(Signed)

L. J. Lurkington

M. D.

, 19

(Address)

102 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cem.

April 3 1920

20 UNDERTAKER

Mr. H. L. Lyons

ADDRESS

1422 Light

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41899

CERTIFICATE OF DEATH.

REGISTERED NO. C

D41899

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 Curtis Ave, Curtis Bay St.; 25 WARD)

2-FULL NAME

(Residence in Baltimore: No. 815 Curtis Ave, Curtis Bay St.; 6 yrs., 17 mos., 17 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

F

4-COLOR OR RACE,

W.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

Sept. 15, 1919
(Month) (Day) (Year)

7-AGE,

6 yrs., 17 mos., 17 ds.
If LESS than 1 day,
....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9-BIRTHPLACE,
(State or Country),

Maryland

10-NAME OF FATHER,

George Jacob Himmel

11-BIRTHPLACE OF FATHER
(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Clara Agnes Kirby

13-BIRTHPLACE OF MOTHER
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Geo. J. Himmel

(Address)

815 Curtis Ave, Curtis Bay

15-

APR 3 - 1920

101.

ROBERT A. LAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH,

April 1st, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

April 1st, 1920, to April 1st, 1920,

that I saw her alive on April 1st, 1920,

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobes pneumonia

(Duration)....yrs....mos....ds.

CONTRIBUTORY
(Secondary)

(Duration)....yrs....mos....ds.

(Signed) Geo. J. Himmel M. D.

April 1st, 1920 (Address) 734 Pennington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill Cem.

DATE OF BURIAL,

April 3rd, 1920

20-UNDERTAKER

M. G. Flynn

ADDRESS

1422 Highland

D41900

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D41900

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2003 W. Lexington St. ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen L. Reiter

(a) RESIDENCE. No. 2003 W. Lexington St. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Late Charles S. Reiter

6 DATE OF BIRTH (month, day, and year) June 27, 1841

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

9

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Sykesville Maryland (State or country)

10 NAME OF FATHER William Frantz

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. Maryland (State or country)

12 MAIDEN NAME OF MOTHER Louisa Gibson

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co. Maryland (State or country)

14 Informant Mrs. Cora B. Stagge (Address) 2003 W. Lexington St.

Robert F. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1920, to April 1, 1920.

that I last saw h. alive on March 31, 1920.

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY Acute Dilatation of Heart (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward Neudorfer, M. D.

, 19 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery

April 5, 1920

20 UNDERTAKER

Joseph L. B. Cook

ADDRESS 1003 M. B. St. Street

TION is very important. See instructions on back of certificates.

APR 3 - 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41901

D41901

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

St Joseph Hosp

REGISTERED NO. C

CITY OF BALTIMORE: (No.

Albion Hotel

ST. 11

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mrs Bertha G Bond

(Residence in Baltimore: No.

Albion Hotel & various

St.: 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F

4-COLOR OR RACE,

W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

February

5th

1882

(Month)

(Day)

(Year)

7-AGE,

38

yrs.

1

mos.

28

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Home

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Sykesville Md.

10-NAME OF FATHER,

James George

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Eugenia B. Berret

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

James B. George

(Address)

Mr. Royal A. Hartwells

15-

Robert F. Harrison,

191

APR 3 - 1920

Burial Permit

Class

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April

Second

1920.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mar. 26

1920,

to

Apr. 2

1920.

that I saw her alive on

Apr. 2

1920.

and that death occurred, on the date stated above, at

12 noon.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction (operation)

(Duration)

yrs.

mos.

8 ds.

CONTRIBUTORY (Secondary)

Myocardial insufficiency

(Duration)

yrs.

mos.

4 ds.

(Signed)

H. B. M. Bluman

M. D.

Apr. 2, 1920 (Address)

St. Joseph's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

4 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Sykesville Md.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Crematorium

April 3rd, 1920

20-UNDERTAKER

Henry J. Hukins & Sons Co

ADDRESS

Orchard

McCollough St

D41902

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41902

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

900 L. Pine

ST.: 17

WARD)

2-FULL NAME

Jennie Snow

(a) RESIDENCE. NO.

900 L. Pine

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Col.

5 Single, Married, Widowed,
or Divorced (write the word)

single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1872

7 AGE

48

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Lawn dress

(b) General nature of industry,
business, or establishment in
which employed (or employer)

041

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Washington, D.C.

10 NAME OF FATHER

Thomas Snow

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Harnett Bell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Washington D.C.

14

Informant
(Address)

George W. Snow

Robert P. Harrison,

Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

170

ST.: 17

WARD)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 2, 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 30, 1920, to April 2, 1920,

that I last saw him alive on April 2, 1920,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. 4 mos. ds.

18 Where was disease contracted
if not at place of death?

at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

John G. Shiffler, M. D.

4/2, 1920 (Address)

206 N. Fulton

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Alexander, Va.

April 3, 1920

20 UNDERTAKER

Daniel Easton

ADDRESS

916
Oa an

TION is very important. See instructions on back of certificate.

APR 3 - 1920

D41903

HEALTH DEPARTMENT--CITY OF BALTIMORE

D41903

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 S Durham ST.: 2 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mieczyslaw Janocha(a) RESIDENCE. NO. 321 S Durham ST., 2 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 23, 19187 AGE Years 1 Months 4 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) md10 NAME OF FATHER Peter Janocha11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)12 MAIDEN NAME OF MOTHER Alexandra Sul13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)14 Informant Peter Janocha (Address) 321 S Durham15 Filed Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-2 192017 I HEREBY CERTIFY, That I attended deceased from March 28, 1920, to April 2, 1920, that I last saw him alive on April 2, 1920, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

gastro enteritis(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? n Date ofWas there an autopsy? nWhat test confirmed diagnosis? n(Signed) T. W. Conklin, M. D.19 20 (Address) 16 E. Bond

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary Church April 3, 1920

20 UNDERTAKER

ADDRESS

T. W. Conklin 924 EEngert

APR 3 - 1920

Burial Permit Clerk.

TION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

D41904

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41904

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 107)

2-FULL NAME

(Residence in Baltimore: No. 107)

REGISTERED NO. C.

ST.: 3

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

APR 3 - 1920

Robert F. Harrison

191

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner)

1910

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-DEERTAKER

ADDRESS

D41905

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41905

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Md. Gen'l. Hosp. St.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Seymour William Ruff

(a) RESIDENCE. NO.

Glydon Md.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar. 27, 1920.

7 AGE

Years

Months

Days

If LESS than
1 day. hrs.
or min.

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md.

10 NAME OF FATHER

Seymour Wm. Ruff

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Roshp Md.

12 MAIDEN NAME OF MOTHER

Mary West.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md.

14

Informant
(Address)Seymour Ruff
Glyndon Md.

19 Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 2 1920

17

I HEREBY CERTIFY, that I attended deceased from

March 27, 1920, to April 2, 1920,

that I last saw him alive on April 1, 1920,

and that death occurred, on the date stated above, at 3 9. m.

The CAUSE OF DEATH* was as follows:

Prematurity

CONTRIBUTORY
(Secondary)Pyelitis in mother
(duration) 1 yrs. mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur Chas. Tiemeyer, M. D.

4/2, 1920 (Address) Md Gen'l. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Friend's Burial Ground April 3 1920

20 UNDERTAKER

ADDRESS

J. F. Elvick Ruston

TION is very important. See instructions on back of certificates.

APR 3 - 1920

D41906

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 2 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Florence E Guertler

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed 2-19-20

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

April 11, 1920 to April 1, 1920

that I last saw him alive on April 1, 1920

and that death occurred, on the date stated above, at 12:45 a. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

About 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. Young M. D.

Address 1508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery April 5th 1920

20 UNDERTAKER

George Schilling & Sons 1126 E. Monument St.

D41907

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41907

CERTIFICATE OF DEATH.

I-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Carter ave* *Raspburg* ST. *27* WARD)2-FULL NAME *John E. Carter*(a) RESIDENCE. NO. *Carter ave* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *20* yrs. *4* mos. *4* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *March 28 1900*7 AGE Years *20* Months *-* Days *4* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Auto Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

J.B. Hatch & Sons

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md*10 NAME OF FATHER *Wm H Carter*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore Md*12 MAIDEN NAME OF MOTHER *Washington D C*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

*Wm H Carter**Carter ave Raspburg*

15

Filed

APR 3 - 1920

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 1, 1920*17 I HEREBY CERTIFY, That I attended deceased from *March 14*, 19*20*, to *Apr. 1*, 19*20*, that I last saw him alive on *Apr. 1*, 19*20*, and that death occurred, on the date stated above, at *8:30 a.m.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, Bilateral (Type I)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

A. S. Harrison

M. D.

4/1, 1920 (Address)

Raspburg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Prospect Hill Cemetery Towson**April 4th 1920*

20 UNDERTAKER

ADDRESS

*George Schilling & Sons**1126 E Monument*

TION is very important. See instructions on back of certificates.

D41908

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41908

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1407 Wilmer Alley* ST.; *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1407 Wilmer Alley* St.; *14* yrs., *12* mos., *12* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH.

March *1874* *1874* (Month) (Day) (Year)

7-AGE.

45 yrs., *12* mos., *12* ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *086*(b) General nature of industry, business, or establishment in which employed (or employer) *Longman*9-BIRTHPLACE, (State or Country), *Maryland*

PARENTS.

10-NAME OF FATHER, *George Johnson*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Hennrich*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James H. Dennis*(Address) *1202 Prestman St*

15-

Filed *1912-12-12*1912-12-12 *For it Clerk* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Apr - 2 - 1920 (Month) (Day) (Year)HEREBY CERTIFY, That I attended deceased from *Feb 24* 19*20*, to *Apr 1* 19*20*,that I saw him alive on *Apr - 1 - 1920*, and that death occurred, on the date stated above, at *79* m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver *4?* (Duration) yrs., mos., ds.CONTRIBUTORY (Secondary) *Influenza*(Signed) *J. H. Dennis* M. D. (Address) *1202 Prestman St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs., mos., ds. In the State... yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Local Cemetery 191...

20-UNDERTAKER

JAMES H. DENNIS

APR 29 1920

1303 PRESTMAN ST.

D41909

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D41909

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *624 Mosher*ST.: *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs John Thomas

(a) RESIDENCE. NO.

624 Mosher

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *24* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Husband of Mary Thomas*

6 DATE OF BIRTH (month, day, and year)

Not known

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*57*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Head Carver

(b) General nature of industry, business, or establishment in which employed (or employer)

035

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Maryland*

10 NAME OF FATHER

*Alexander Thomas*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Maryland*

12 MAIDEN NAME OF MOTHER

*Annie King*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Ind. C.*

14

Informant
(Address)*Annie Thomas
624 Mosher St*

15

Filed

19

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 1 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

Grade 2, 19*20*, to *April 1*, 19*20*that I last saw him alive on *April 1*, 19*20*and that death occurred, on the date stated above, at *7 a. m.*

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Severe colitis*
(duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Physical*(Signed) *Edward J. Wheatley*, M. D.*4/1/20* (Address) *1220 Smith Hill Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Auburn *APR 24 1920*

20 UNDERTAKER

ADDRESS

*JAMES H. DENNIS**1303 PRESTMAN ST.*

NOTION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41910

D41910

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH, *June 13, 1848*
(Month) (Day) (Year)

7-AGE, *71* yrs. *9* mos. *19* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *At home*
(b) General nature of industry, business, or establishment in which employed (or employer) *ooo*

9-BIRTHPLACE, (State or Country), *Germany*

10-NAME OF FATHER, *Valentine Dennis*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER *Margaret Schubert*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Grace Fountain*(Address) *1007 Mc Donogh*

15-

Robert F. Harrison,
191
Registrar.

APR 3 - 1920

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *April 1, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY. That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

the on and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy Heart Disease
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Heart Disease*

(Signed) *W. H. Bailey* M. D.
(Coroner.)
4-1, 1210 (Address) *W. H. Bailey*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Baltimore *April 3 1920*

20-UNDERTAKER ADDRESS *1739*

Girkler & Girkler *Eager*

important. See instructions on back of certificate.

D41911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D41911

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 737 N. Patterson Park ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 737 N. Patterson Park St.; 51 yrs., 1 mos., 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH,

Sept. 12, 1847
(Month) (Day) (Year)

7-AGE,

72 yrs., 6 mos., 18 ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

at home

(b) General nature of industry, business, or establishment in which employed (or employer).

037

9-BIRTHPLACE,

(State or Country),

Hampton, Va.

10-NAME OF FATHER,

David Johnson

11-BIRTHPLACE OF FATHER

(State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER

(State or Country),

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm. L. Ross

(Address)

737 N. Patterson Park Ave

15-

Robert P. Harrison,

Registrar.

APR 3 - 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 1, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

March 1910, to April 1, 1920,

that I saw him alive on April 1, 1920,

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) ... yrs. ... mos. 7 ds.CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Harrison M. D.

April 1, 1920 (Address) 1301 Patterson Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cem.

DATE OF BURIAL,

April 5, 1920

20-UNDERTAKER

Zirkler + Zirkler

ADDRESS

1739 E. Equest

D41912

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41912

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3740 Hickory Ave WARD)

2-FULL NAME

(a) RESIDENCE. No. 3740 Hickory Ave WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

If nonresident, give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)Robert P. Harrison
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

June 15, 1920, to April 1, 1920.

that I last saw him alive on April 1, 1920.

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Condition of patient

(Signed) R. R. Nunnally, M. D.

42, 1920 (Address) 3643 Chestnut St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41913

CERTIFICATE OF DEATH.

104
REGISTERED NO. C

D41913

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 N. Broadway ST.; 6 WARD)

2-FULL NAME

Robert Lange
(Residence in Baltimore: No. 426 N. Broadway St.; 90 yrs., 1 mos., 6 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

WIDOWEDOR DIVORCED(Write the word.) Widowed

6-DATE OF BIRTH.

February 27, 1830
(Month) (Day) (Year)

7-AGE.

90 yrs., 1 mos., 6 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired9-BIRTHPLACE,
(State or Country),Germany

10-NAME OF FATHER,

Robert Lange11-BIRTHPLACE OF FATHER
(State or Country),Germany

12-MAIDEN NAME OF MOTHER

Leche Waltjen13-BIRTHPLACE OF MOTHER
(State or Country),Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

APR 3 - 1920

Robert P. Harrison,

Registrar.

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

April 2nd, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Mar 22 1920, to April 2 1920, that I saw him alive on Apr 2 1920, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Sprangulated Aneurysm
hernia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)Septicemia
pneumonia (Duration).....yrs.....mos.....ds.(Signed) W. W. Harrison M. D.April 3, 1920 (Address) 805 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Immanuels Church

DATE OF BURIAL.

Apr 4, 1920

20-UNDERTAKER

Louis Heemann 328 Broad

ADDRESS

way

D41911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41911

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *University Hospital*)ST. *4*

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *208 Jasper*)St.; yrs. *life* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

Don't know, 1 (Month) (Day) (Year)

7-AGE,

75 about yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Md.

10-NAME OF FATHER,

Don't know

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant *Christina Jackson*)(Address) *216 Jasper St*

15-

Robert P. Harrison

Filed

191

Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 29, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, or

autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

*Insulation of electrical wires
dur. to burning of wires, pipes
(Duration) 2 hrs. 15 mos. ds.*

CONTRIBUTORY (Secondary)

Accident
(Duration) *a few hours* yrs. mos. ds.(Signed) *R. P. Harrison* M. D.
(Coroner.)4-1-1920 (Address) *117 N. Saratoga St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Annaphs Chh

DATE OF BURIAL,

April 4, 1920

20-UNDERTAKER

John H. Owen

ADDRESS

538 Ralph St

D41915

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41915

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2102 Etting* ST.; *14* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *2102 Etting* St.; *30* yrs., *-* mos., *-* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

Col

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Not known, 1874
(Month) (Day) (Year)

7-AGE

46
yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Hand 041
Laundry*9-BIRTHPLACE,
(State or Country),*va*

PARENTS.

10-NAME OF FATHER,

*Not known*11-BIRTHPLACE OF FATHER
(State or Country),*Not known*

12-MAIDEN NAME OF MOTHER

*Not known*13-BIRTHPLACE OF MOTHER
(State or Country),*Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Came Crawford

(Address)

2037 Dunbar St.

15-

Robert F. Harrison,

191

Burial Permit

Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 31, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*March 25 to March 31, 1914*that I saw him alive on *March 31, 1914*and that death occurred, on the date stated above, at *11:30* p.m.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. H. Harrison* M. D.*411 E. 1st* (Address) *117 N. Calver*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Local Cemetery

DATE OF BURIAL,

April 3, 1914

20-UNDERTAKER

John H. Owens

ADDRESS

538 N. Calver

important. See instructions on back of certificate.

APR 3 - 1920

D41916

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41916

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST.

WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 60 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Single.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

APR 3 - 1920

Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1920

17

HEREBY CERTIFY, That I attended deceased from

April 1, 1920, to April 1, 1920,

that I last saw him alive on April 1, 1920,

and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clavical

(Signed)

19 (Address) 1303 N. 2nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Harvard Cemetery

20 UNDERTAKER

J. Ahrens & Co.

ADDRESS

1611 Madison Ave.

D41917

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41917

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2231 E. Monument ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Laurentthal(a) RESIDENCE. NO. 2231 E. Monument ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leri Laurentthal6 DATE OF BIRTH (month, day, and year) Ankum 18457 AGE Years 75 Months — Days — If LESS than 1 day, hrs. — or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) 000(c) Name of employer —9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Ankum11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia12 MAIDEN NAME OF MOTHER Ankum13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14

Informant (Address) Jack Lewis 141 E. Baltimore

APR 3 - 1920 ROBERT F. HARRISON, Jr.

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-2nd 192017 I HEREBY CERTIFY, That I attended deceased from October, 1919, to April 1, 1920, that I last saw him alive on April 1, 1920, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease(duration) several yrs. mos. ds.CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? no(Signed) Dr. C. Deegen, M. D.7/2, 1920 (Address) 1702 E. Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Friendship Cem4-4 1920

20 UNDERTAKER

ADDRESS

Jack Lewis141 E. Baltimore

TION is very important. See instructions on back of certificates.

D41918

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41918

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2107 Maryland Ave St.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm H Tapscott(Residence in Baltimore: No. 2107 Maryland Ave St.; 27 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male4-COLOR OR RACE White5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, Aug 29, 1856

(Month)

(Day)

(Year)

7-AGE, 63 yrs., 7 mos., 4 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or occupation,
kind of work. Street car conductor(b) General nature of industry, business, or establishment in which employed (or employer) 0789-BIRTHPLACE,
(State or Country), Laurens Co. Va.10-NAME OF FATHER, Henry Tapscott11-BIRTHPLACE OF FATHER
(State or Country), Laurens Co. Va.12-MAIDEN NAME OF MOTHER Elizabeth J. Maston13-BIRTHPLACE OF MOTHER
(State or Country), Annapolis Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H Tapscott Jr.(Address) 12 Laura Road

15-

Robert F. Harrison,

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 2nd, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 15, 1920, to April 2, 1920,that I saw him alive on April 2, 1920,and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis(Duration) 5 yrs., mos., ds.CONTRIBUTORY (Secondary) Influenza(Duration) 7 yrs., 4 mos., ds.(Signed) Robert F. Harrison M. D.April 5, 1920 (Address) 211 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Gruid Ridge CemeteryDATE OF BURIAL, Apr 5, 192020-UNDERTAKER, Harry AnnacoxADDRESS, 4204 Ridgemoor Ave

Important. See instructions on back of certificate.

APR 3 - 1920

D41919

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41919

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1220 E. Foxington* ST.: *5th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thomas Hargis

(a) RESIDENCE. No.

1220 E. Foxington ST., *5th* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Husband Dead

6 DATE OF BIRTH (month, day, and year)

1866

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

64

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pocomoke City Md

10 NAME OF FATHER

Geo. W. Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Thos Marshall 1127 E. Foxington St.

15

File

APR 3 - 1920

Robert F. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 1, 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 14, 1920, to April 1, 1920,*that I last saw him alive on *April 1, 1920,*and that death occurred, on the date stated above, at *7:50 P. M.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) yrs. *8* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Robert F. Green* M. D.42, 1920 (Address) *120 1/2 Airguth St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Pocomoke City Md.**Apr 4 1920*

20 UNDERTAKER

ADDRESS

*Samuel Hensley**57 N. Hollis*

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41920

CERTIFICATE OF DEATH.

*120

D41920

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1114 N. Calvert.

ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles H. McCullough, Jr.

(a) RESIDENCE. NO.

Buffalo N.Y.

ST.:

WARD.

480 Oakland Place

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

18

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 25 - 1868

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

52.

3

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

President 086

(b) General nature of industry, business, or establishment in which employed (or employer)

Hicksona Steel Corp.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Philadelphia Pa

10 NAME OF FATHER

Charles H. McCullough Jr.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

New York.

12 MAIDEN NAME OF MOTHER

Ely S. Platt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

New York

14

Informant (Address)

Dr. Miller 900 St Paul St.

15

Filed

Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 3 1920

17

I HEREBY CERTIFY, That I attended deceased from

1920, to April 3, 1920,

that I last saw him alive on April 3, 1920,

and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Chemistry

(Signed) Sydney R. Miller, M. D.

, 19 (Address) 900 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Buffalo N.Y.

April 3 1920

20 UNDERTAKER

Henry H. Jenkins Sons

ADDRESS

McCulloh Co Orchard

TION is very important. See instructions on back of certificates.

APR 3 - 1920

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41921

CERTIFICATE OF DEATH.

91 D41921

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2138 Druid Hill, 14 WARD)

2-FULL NAME

(a) RESIDENCE. No. 2238 Druid Hill

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 9 mos. 2 ds.

WARD.

(If nonresident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Cauc

5 Single, Married, Widowed,

or Divorced (write the word)

Widower

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Mary Noel

6 DATE OF BIRTH (month, day, and year)

June 30-1850

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

69 9 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

Lucie Noel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

West India

14

Informant

(Address)

Mary E. N. Jones
2238 Druid Hill

15

Informant

(Address)

Robert F. Harrison,
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 2 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 1, 1920, to April 2, 1920

that I last saw him alive on April 2, 1920

and that death occurred, on the date stated above, at 7.45 P. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed)

F. C. Lusk, M. D.
1313 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral

Apr 5 1920

20 UNDERTAKER

M. F. Lusk & Sons 1827 W. North Ave.

TION is very important. See instructions on back of certificates.

APR 3 - 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41922

D41922

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 E. Montgomery

ST.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louisa Harrington

(a) RESIDENCE. No. 123 E. Montgomery

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Cap't William S. Harrington

6 DATE OF BIRTH (month, day, and year) Jan, 6 1841

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 79 3 27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pennsylvania

10 NAME OF FATHER William Moffitt

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER Louisa Kaltenbach

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14 Informant William S. Harrington

(Address)

123 E. Montgomery St.

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 2 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 16 1919, to Apr 2 1920, that I last saw him alive on Apr 2 1920

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) same yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J. M. D.

4/3, 1920 (Address)

1219 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

LONDON PARK

DATE OF BURIAL

APR -5 1920

20 UNDERTAKER

JOHN F. DENNY

ADDRESS

715 LIGHT ST.

TION is very important. See instructions on back of certificates.

APR 3 - 1920 Burial Permit Clerk

D41923

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41923

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2702 Roslyn Ave. St.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2702 Roslyn Ave. St.; 61 yrs., 6 mos., 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH.

Sept

16

1858

(Month)

(Day)

(Year)

7-AGE,

61

yrs.

6

mos.

16

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

At home

(b) General nature of industry, business, or establishment in which employed (or employer).

037

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

PARENTS.

10-NAME OF FATHER,

Henry G. Golebusch

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Christine G. Halger

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Charles Feick

(Address)...

2702 Roslyn Ave

15-

FILED

APR 3 - 1920

Robert P. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April

1

1920

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 10 1920, to Apr 1 1920.

that I saw her alive on Apr 1 1920.

and that death occurred, on the date stated above, at 3:55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Bladder

(Duration)

2

yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration)

yrs.

mos. ds.

(Signed)...

G. A. Strauss M. D.

Apr 2, 1920. (Address) 1935 N. 20th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted,
if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL,

LOUDON PARK

DATE OF BURIAL,

APR - 3 1920

20-UNDERTAKER

JOHN F. DENNY

ADDRESS

715 LIGHT ST.

D41924

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41924

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *501* *Walnut ally* ST. *17* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Maud Washington*

(a) RESIDENCE, No. *501 Walnut ally* ST. *17* WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *7* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *0* yrs. *0* mos. *0* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *7*

4 COLOR OR RACE *Colored*

5 Single, Married, Widowed, or Divorced (write the word) *m*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan 1*

7 AGE

Years

Months

Days

If LESS than 1 day, *hrs.* or *min.*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Lumber*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Washington, D.C.*

10 NAME OF FATHER *Latham S. Spigg*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Margaret Spigg*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert P. Harrison

Registrar

APR 3 - 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *3/31/1920*

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 29/1920, to *Mar. 31, 1920*

that I last saw him alive on *Mar 31, 1920*

and that death occurred, on the date stated above, at *9:45 a.m.*

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *yes*

What test confirmed diagnosis? *Physical*

(Signed)

Dr. H. Thompson, M. D.

(Address) *101 9th Street Hill*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITAL

20 UNDERTAKER

ADDRESS

Commissioner Health

APR 3 1920

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D41925.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST.: *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Alma Nicolson*(a) RESIDENCE. NO. *16 Maple St. St. Thomas Ontario* WARD.

(Usual place of abode)

(If nonresident give city and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *X*6 DATE OF BIRTH (month, day, and year) *June 17 - 1910*7 AGE Years *9* Months *9* Days *26* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *child jgg*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Canada*10 NAME OF FATHER *James Wesley Nicolson*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Canada*12 MAIDEN NAME OF MOTHER *Ida Martin*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Canada*

PARENTS

14 Informant (Address) *J.H.N. Records*

APR 3 - 1920 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 2* 19*20*17 I HEREBY CERTIFY, That I attended deceased from *April 1st*, 19*20*, to *April 2*, 19*20*, that I last saw him alive on *April 2*, 19*20*, and that death occurred, on the date stated above, at *3:15 P* m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus(duration) *1* yrs. mos. ds.CONTRIBUTORY (Secondary) *None*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Urinary findings -*(Signed) *Harold L. Higgins*, M. D.4/2, 19*20* (Address) *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Thomas Ontario Canada *Apr. 3* 19*20*

20 UNDERTAKER

ADDRESS

Wm. L. Black 927 N. Broadway

Tion is very important. See instructions on back of certificates.

D41926

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D41926

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Heights* ST. *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Anna R. Dennis

(a) RESIDENCE. NO.

Bentley Springs, Md.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.How long in U. S., if of foreign birth? yrs. mos. ds. *22*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

(or) WIFE of

J. Harry Dennis

6 DATE OF BIRTH (month, day, and year)

Unknown 1863

7 AGE

Years

Months

Days

If LESS than
1 day, hr.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

D. Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

E. Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant

(Address)

E. Thomas Stewart

15

Filed

19

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 3 1920

17

I HEREBY CERTIFY, That I attended deceased from

*February 11th 1920, to April 3rd 1920,*that I last saw him alive on *April 3 1920,*and that death occurred, on the date stated above, at *255* m.

The CAUSE OF DEATH* was as follows:

*Carcinoma of liver
on 2nd of April*(duration) yrs. mos. ds. *5*

CONTRIBUTORY (Secondary)

Hemorrhage(duration) yrs. mos. ds. *7*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

Trueman, M. D.

(Signed)

19

(Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Loudon Park**April 5 1920*

20 UNDERTAKER

ADDRESS

*John Attitell**1301 N. Fayette*

TION is very important. See instructions on back of certificates.

APR 3 - 1920

D41827

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41927

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2324 E. FayetteST.: 6 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony T. Seibhardt(a) RESIDENCE. No. 2324 E. Fayette
(Usual place of abode)ST. 6 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 11 mos. 2 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) May 30 19077 AGE Years 13 Months 11 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Scholar at

(b) General nature of industry, business, or establishment in which employed (or employer)

School

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Balto Md.

10 NAME OF FATHER

Michael Seibhardt11 BIRTHPLACE OF FATHER (city or town)
(State or country)Balto Md.

12 MAIDEN NAME OF MOTHER

Catharine Wagner13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Balto Md.

14

Informant
(Address)Robert F. Harrison,

APR 8 - 1920. 19 Burial Permit Clark Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2nd 1920

17 I HEREBY CERTIFY, That I attended deceased from

Feb 26 1920, to Apr 2 1920,that I last saw him alive on Apr 1 1920,and that death occurred, on the date stated above, at 2:35 a.m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis(duration) — yrs. 1 mos. 5 ds.CONTRIBUTORY
(Secondary)Acute Articular Rheumatism
(duration) — yrs. 1 mos. 10 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed)

Robert F. Harrison M. D.

(Address)

1229 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer CemeteryApril 5th 1920

20 UNDERTAKER

ADDRESS

Lilly & Zeller403 S. Wolfe St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41929

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

Union Protestant Infirmary ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mr. Fred S. Satterfield 14

(Residence in Baltimore: No.

St.; - yrs., - mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE, married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Nov. 4, 1884
(Month) (Day) (Year)

7-AGE,

35 yrs. 4 mos. 28 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Lawyer

9-BIRTHPLACE,
(State or Country),

Arkansas

10-NAME OF FATHER,

W. T. Satterfield

11-BIRTHPLACE OF FATHER
(State or Country),

Ida.

12-MAIDEN NAME OF MOTHER

Miss Mary Moffat

13-BIRTHPLACE OF MOTHER
(State or Country),

S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. M. A. Tellier

(Address) Little Rock - Ark.

15-

Filed

Robert P. Harrison,

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr. 2, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mar 27 1920, to Apr 2 1920,

that I saw him alive on Apr 2 1920,

and that death occurred, on the date stated above, at 11:15 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus

(Duration) Terminal yrs. mos. ds.

CONTRIBUTORY... Sarcinoma, upper part
(Secondary)

(Duration) yrs. 6 mos. ds.

(Signed) J. M. A. Tellier M. D.

April 3, 1920. (Address) Union Protestant Infirmary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 6 ds. In the State yrs. mos. 14 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Little Rock, Arkansas.

19-PLACE OF BURIAL OR REMOVAL,

Little Rock - Arkansas

DATE OF BURIAL,

April 3, 1920

20-UNDERTAKER

William Cook

ADDRESS

502 E. North Ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41930

D41930

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1413 Battery* ST.: *24* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lilia A. Browe(a) RESIDENCE. No. *1413 Battery* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *20* yrs. mos.

ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*George F. Browe*

6 DATE OF BIRTH (month, day, and year)

July 14-1872

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*47**8**18*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Pa.*

10 NAME OF FATHER

Chas Butler

11 BIRTHPLACE OF FATHER (city or town)

Rochester

(State or country)

12 MAIDEN NAME OF MOTHER

Sarah Tappin

13 BIRTHPLACE OF MOTHER (city or town)

Pa.

(State or country)

14

Informant
(Address)*Mr. George F. Browe
1413 Battery**Robert P. Harrison*

Registrar

Burial Permit Clerk.

APR 3 - 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/2 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

*3/6/20*19 *20*to *Apr 2*19 *20*

that I last saw he alive on

*Apr 2*19 *20*and that death occurred, on the date stated above, at *12:45* m.

The CAUSE OF DEATH* was as follows:

*Chronic valvular heart disease
Chronic interstitial nephritis*CONTRIBUTORY *unknown*
(duration) yrs. mos. ds.*Embolus in rt. femoral*
(Secondary)
+ fungous of foot & leg
(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *yes* Date of *3/29/20*Was there an autopsy? *no*What test confirmed diagnosis? *Physical*(Signed) *M. D.*4/3, 1920 (Address) *1319 Light St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cedar Hill Cem.**4/5* 19 *20*

20 UNDERTAKER

ADDRESS

*L. F. M. Cully**130 E. Fort*

D41931

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D41931

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 S 14th ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Neal K. Clarke

(a) RESIDENCE. NO.

633 S 14

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

1 yrs. 4 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar 5-1915

7 AGE

Yrs

Months

Days

If LESS than 1 day, hrs. or min.

1423

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Joe P. Clarke

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Edith Foster

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant (Address)

Joe P. Clarke633 S 14thRobert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 2 1920

17

I HEREBY CERTIFY, That I attended deceased

3/201920

to

4/21920that I last saw him alive on 4/1/20 19and that death occurred, on the date stated above, at 4 2

The CAUSE OF DEATH* was as follows:

Acute Illness

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Dr. J. H. Hance

M. D.

Address

2424 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Essex Co Va

DATE OF BURIAL

April 7 1920

20 UNDERTAKER

John Reelick

ADDRESS

2008 Belair

CAUSE OF DEATH is very important. See instructions on back of certificates.

APR 3-1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41932

CERTIFICATE OF DEATH.

28 D41932
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 N. Bradford ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 915 N. Bradford St. St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Married

6-DATE OF BIRTH,

Unknown, 1.....
(Month) (Day) (Year)

7-AGE,

20If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
Housewife
0379-BIRTHPLACE,
(State or Country),Ba. Ct.

10-NAME OF FATHER,

Joseph Kotvick11-BIRTHPLACE OF FATHER
(State or Country),Bohemia

12-MAIDEN NAME OF MOTHER

Mary Brown13-BIRTHPLACE OF MOTHER
(State or Country),Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....
Louis Kassy(Address).....
915 N. Bradford St.

15-

APR 4 - 1920
Filed.....

ROBERT E. KRAUTER

BUTLER STREET CLAY
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April, 1, 1910
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
February 13 1910, to April 1 1910,
that I saw her alive on April 1 1910,
and that death occurred, on the date stated above, at 10.00 m.
The CAUSE OF DEATH* was as follows:.....
Pulmonary Tuberculosis
.....
(Duration) 2-3 yrs. mos. ds.CONTRIBUTORY
(Secondary)..... (Duration) yrs. mos. ds.
(Signed) Frank J. Ayk M. D.
Apr 2, 1910 (Address) 2005 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

DATE OF BURIAL,

Apr 5, 1910

20-UNDERTAKER

Frank Erickson

ADDRESS

1406 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D41933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

D41933

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Union Hill*)

2-FULL NAME

(Residence in Baltimore: No. *3075 Cedar Ave*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. (yrs. *4*) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

APR 4 - 1920

ROBERT E. KRAUTER

Bureau of Health

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed) *John Harrison* M. D.

(Address) *322 Roland Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OR BURIAL, OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

1 PLACE OF DEATH.

CITY OF BALTIMORE: (NO. 317 South Wolfe

ST. 4 WARD)

2-FULL NAME.....FRANCES WELZANT.....

(Residence in Baltimore: No. 317 South Wolfe

St.: 36 yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female,	4-COLOR OR RACE White,	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow,
------------------	---------------------------	---

6-DATE OF BIRTH January 16- /1845.
(Month) (Day) (Year)

7-AGE 75 yrs. 2 mos. 18 ds. If LESS than 1 day, _____ hrs., _____ or _____ min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work At home,

(b) General nature of industry, business, or establishment in which employed (or employer)

0-BIRTHPLACE
(State or country)
Giesson German Poland.

10-NAME OF FATHER
Walzent.

NTS 11-BIRTHPLACE
OF FATHER
(State or country) Giessen German Poland,

12-MAIDEN NAME
OF MOTHER Antonia Marcinkowska.

13-BIRTHPLACE
OF MOTHER
(State or country) Giessen German Poland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....Helen Dembek,

(Address)..... 317 So. Wolfe Street

15- APR 4 - 1920 ROBERT E. KRAUTER

Filed 191 **Barial Family Club**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Apr 2, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from
March 20, 1970, to April 20, 1970,
 that I saw her alive on April 20, 1970,
 and that death occurred, on the date stated above, at 9:00 p.m.
 The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(Duration) yrs mos. 6

Contributory
(SECONDARY)

(Duration) yrs mos.

(Signed), *Clayton Loveston* M.

Apr 21 1970 [Address] 2124 E. Baileys

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS]

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted,
if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
217	11/11/1918
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300	11/11/1918

Fritz Rosenberg

20. SURNAMES	ADDRESS
M. F. Sadowski	1015 E. 1st St.

Gowrey.
HEALTH DEPARTMENT—CITY OF BALTIMORE

D41935

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

151 D41935
REGISTERED NO. C

CITY OF BALTIMORE: (No. 406 E Chon ST.; 10 WARD)

2-FULL NAME

(Residence in Baltimore: No. 406 E Chon / St.:yrs.,.....mos.....ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M 4-COLOR OR RACE. W 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single (Write the word.)

6-DATE OF BIRTH, 4 3, 1920 (Month) (Day) (Year)

7-AGE,yrs.....mos.....ds. IT LESS than 1 day, 2 hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed

APR 4 - 1920

ROBERT E. REAUTEH

Burial Place

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 3, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4-3 1920, to 4-3 1920, that I saw him alive on 4-3 1920, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia with S. aureus. (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Signed) Dr. J. E. Biddle M. D. 4/3, 1920 (Address) 814 E. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

D41936

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D41936
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1338 N. Luzern ST.; 8 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1338 N. Luzern St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Oct 6, 1876
(Month) (Day) (Year)

7-AGE,

43 yrs., 5 mos., ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Post Office Clerk

9-BIRTHPLACE, (State or Country).

Baltimore Md.

10-NAME OF FATHER,

Sebastian Langhert

11-BIRTHPLACE OF FATHER

(State or Country), Germany.

12-MAIDEN NAME OF MOTHER

Helen Albrecht

13-BIRTHPLACE OF MOTHER

(State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Johanna Langhert

(Address)

1338 N. Luzern St.

15-

ROBERT E. KRAUTER

Filed

APR 4 - 1920

Baltimore City Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 2, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 29, 1920, to April 2, 1920,that I saw him alive on April 2, 1920,and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edwin B. Ferry, M. D.Apr. 3, 1920. (Address) 223 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Holy Redeemer

DATE OF BURIAL.

April 4, 1920

20-UNDERTAKER

Frank A. Link

ADDRESS

910 N. Gay St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41937

CERTIFICATE OF DEATH.

9 D41937

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Oakfield and Garrison Boul.* ST.: *5* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Dominic Twardowski*(a) RESIDENCE. NO. *124 Elm Str - Curtis Bay* ST.: *5* WARD.

(Usual place of abode)

WARD.

Length of residence in city or town where death occurred *4* yrs. *2* mos. *4* ds. How long in U. S., if of foreign birth? *4* yrs. *2* mos. *4* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Male**White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Chico*6 DATE OF BIRTH (month, day, and year) *Jan 28 - 1916*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*2**2**4*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

" "

(c) Name of employer

" "

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Frank Twardowski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Austria

12 MAIDEN NAME OF MOTHER

Marcelle Tomar

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Austria

14

Informant (Address)

*1 Towardowski
Curtis Bay*

15

APR 4 - 1920

ROBERT I. FRAUTER
Registrar

Burial Permit 0100

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 3 1920*

17

HEREBY CERTIFY, That I attended deceased from

*April 1, 1920, to April 3, 1920,*that I last saw him alive on *April 3, 1920,*and that death occurred, on the date stated above, at *2 P. m.*

The CAUSE OF DEATH* was as follows:

*Diphtheria
(Tonsillar)*(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *1* ds.

18 Where was disease contracted

if not at place of death?

Unknown

Did an operation precede death?

h Date of *—*

Was there an autopsy?

h

What test confirmed diagnosis?

Bacteriological

(Signed)

Wm. P. Hill

M. D.

, 19

(Address)

4740 0000 Ruston Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Rosary**4/4 1920*

20 UNDERTAKER

ADDRESS

Wm. Twardowski 1618 Co

TION is very important. See instructions on back of certificates.

D41938

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41938

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 Russell ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lena M. Bradley

(a) RESIDENCE, No.

1024 Russell

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

41 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofJonathan J. Bradley

6 DATE OF BIRTH (month, day, and year)

Aug 3 - 1878

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

41730

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Balto. Md

10 NAME OF FATHER

John Schmidt

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto. Md

12 MAIDEN NAME OF MOTHER

Catharine Winkler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Kentucky

14

Informant
(Address)Jonathan J. Bradley
1024 Russell St

15

APR 4 - 1920

ROBERT R. LEAUTER

Registrar

Burial Permit: 0140

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4 - 2nd 1920

17

I HEREBY CERTIFY, That I attended deceased from

Dec 1912, 1912, to April, 1920.that I last saw her alive on March 31, 1920.and that death occurred, on the date stated above, at 8:40 a.m.

The CAUSE OF DEATH* was as follows:

Bright's Disease(duration) 10 yrs. — mos. — ds.CONTRIBUTORY
(Secondary)Valvular heart disease(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of —

Was there an autopsy?

No

What test confirmed diagnosis?

Micro

(Signed)

Raymond J. Kline, M. D.

19 (Address)

1024 Russell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral CemeteryApril 5 1920

20 UNDERTAKER

ADDRESS

James Dignan & Son1024 Russell St

CASES OF DEATH IN BALTIMORE, SO THAT IT MAY BE PROPERLY CLASSIFIED. LAST STATEMENT OF OCCURRENCE. See instructions on back of certificates.

D41939

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *418, Police Station* ST. *6*)2-FULL NAME *Mat. V. Houbitz* (known as *Max V. Fisher*)(Residence in Baltimore: No. *426 N. Duncan*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *alt*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *S.*6-DATE OF BIRTH, *Feb 10th*, 18737-AGE, *47* yrs., *1* mos., *21* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Huckster*
(b) General nature of industry, business, or establishment in which employed (or employer) *045*9-BIRTHPLACE, (State or Country), *Germany*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Agnes Schmitt*(Address) *426 N. Duncan*

15-

Filed

APR 4 - 1920

ROBERT B. KRAUTER

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 2*, 1920

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)thereof and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.)

I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging in cell at Police House

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Signed) *W. B. D. Riley*

(Coroner)

M. D.

413, 1920 (Address) *413*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London OK*DATE OF BURIAL, *4/5*, 192020-UNDERTAKER *Philip Henry O'Leary*ADDRESS *2016*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D41940

CERTIFICATE OF DEATH

41 D41940

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 219 St. Luzerne ST. 7 WARD)

2-FULL NAME

Estherine Rump
819 St. Luzerne

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 819 St. Luzerne Sr. 72 yrs. 6 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female	4-COLOR OR RACE White	5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married
6-DATE OF BIRTH Sept 13, 1887		
7-AGE 72 yrs. 6 mos. 19 ds.		
8-OCCUPATION Housework at Home		

9-BIRTHPLACE
(State or country)

Balto

PARENTS

10-NAME OF FATHER

Henry Pausch

11-BIRTHPLACE OF FATHER
(State or country)

Md

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or country)

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

August Rump

(Address)

819 St. Luzerne

15.

APR 4 - 1920

ROBERT B. KRAUTER

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Apr 1, 1920

17. I HEREBY CERTIFY, That I attended deceased from

Medicine, 1915 to Apr 1, 1920
that I saw her alive on Mar 29, 1920
and that death occurred, on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:

Carcinoma of Peritoneum

(Duration) 2 yrs. 6 mos. 19 ds

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Dr. C. J. Rump M. D.

Apr 1, 1920 (Address) 819 St. Luzerne

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Schwartz Cem.

DATE OF BURIAL

Apr 5, 1920

20-UNDERTAKER

Philip Herwig

ADDRESS

2016 Orleans

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41941

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 Argyle Ave ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Thomas J. Billups(Residence in Baltimore: No. 1204 Argyle Ave St. 30 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIEDWIDOWEDOR DIVORCED

(Write the word.)

6-DATE OF BIRTH,

March, 1871
(Month) (Day) (Year)

7-AGE,

49 yrs., — mos., — ds.
If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Cook
B. & O. R.R.9-BIRTHPLACE,
(State or Country),Virginia

10-NAME OF FATHER,

Benny Billups11-BIRTHPLACE OF FATHER
(State or Country),Va

12-MAIDEN NAME OF MOTHER

Sarah Dell13-BIRTHPLACE OF MOTHER
(State or Country),Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophina Billups(Address) 1204 Argyle Ave

15-

Filed

APR 4 - 1920

ROBERT E. KRAUTER

Baptist Minister

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March 31, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 21 1920, to March 31 1920that I saw him alive on March 31 1920and that death occurred, on the date stated above, at 17:30 m.

The CAUSE OF DEATH* was as follows:

Bright Disease(Duration) ... yrs. ... mos. 10 ds.CONTRIBUTORY
(Secondary)(Duration) ... yrs. ... mos. 10 ds.(Signed) C. H. Finer M. D.April 3, 1920. (Address) 712 S. Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

MT. Auburn

DATE OF BURIAL,

April 4, 1920

20-UNDERTAKER

John H. Toadum

ADDRESS

1204 Argyle St

important. See instructions on back of certificate.

Baltimore, Md.,
April 12th, 1920.

Health Department,
City Hall,
City.

Dear Sirs:

On March 31st, 1920, I signed the death certificate of Thomas B. Billups, who formerly lived at 1204 Argyle Avenue. gave his age as 49 years, which was a mistake on my part. The correct age of Thomas B. Billups at the time of his death was 45 years. Kindly correct the same on your record and oblige

Yours respectfully,

C. H. Fowler M. D.

City of Baltimore,
State of Maryland, to wit:

On this 12th Day of April, 1920, personally appeared before me a Notary Public in and for the City of Baltimore, State of Maryland, Dr. Charles H. Fowler, who made oath in due form of law that the above statement is correct.

Minnie B. Lewis
Notary Public.

D41942

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41942

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1129 Carrollton ST.; 16 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1129 Carrollton St.; 48 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH,

March, 1, 1920
(Month) (Day) (Year)

7-AGE,

48 yrs. — mos. — ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).At home
0379-BIRTHPLACE,
(State or Country),

Baltimore, Maryland

10-NAME OF FATHER,

Perry Reed

11-BIRTHPLACE OF FATHER
(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Henrietta Perry

13-BIRTHPLACE OF MOTHER
(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Young(Address) 1129 Carrollton Ave

15-

APR 4 - 1920

Filed

191

ROBERT E. KRAUTER

Burial Permitted

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April, 1, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from March 27 1920, to April 1 1920
that I saw her alive on April 1 1920and that death occurred, on the date stated above, at 2450 m.

The CAUSE OF DEATH was as follows:

Bright's Disease

(Duration) yrs. 1 mos. 5 ds.CONTRIBUTORY
(Secondary)(Duration) yrs. 1 mos. 5 ds.(Signed) C. H. Foster M. D.April 7, 1920 (Address) 712 Ray Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn

DATE OF BURIAL,

April 4, 1920

20-UNDERTAKER

Jno H. Toadum & Co

ADDRESS

143

important. See instructions on back of certificate.

D41943

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41943

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *608 S. Milton Ave.* ST.: *1* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Natharine Hokamp

(a) RESIDENCE. NO.

608 S. Milton Ave.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

68 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

68 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*The late Anton Hokamp*

6 DATE OF BIRTH (month, day, and year)

1840

7 AGE

80

Years

Months

Days

If LESS than

1 day, hrs.

or min.

000

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Germany*

10 NAME OF FATHER

Joseph Scharf

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Julien Ann

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant
(Address)*Mrs. Mary Sommer
608 S. Milton Ave.*

15

Filed

*APR 4 - 1920**ROBERT F. KRAUTER*Registrar
Burial Permit *01020*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 3* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from
March 1st 19 *20*, to *Apr 3rd* 19 *20*,
that I last saw h. *2* alive on *Apr. 2nd* 19 *20*,
and that death occurred, on the date stated above, at *5.45 A.M.*

The CAUSE OF DEATH* was as follows:

Cortic Insufficiency(duration) yrs. *one* mos. - ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Herman J. Giering* M. D.*Apr 3, 1920* (Address) *1400 Eastern Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Sacred Heart Ave.**April 6 1920*

20 UNDERTAKER

ADDRESS

*Lilly and Jailer**403 S. Wolfe*CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41944

D41944

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3317 Fleet St.* ST.; *26* WARD)

REGISTERED NO. C

2-FULL NAME

Anna Marie Kraemer

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *3317 Fleet St.*St.; *Lt.* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

December 29th 1914
(Month) (Day) (Year)

7-AGE,

5 yrs. 3 mos. 3 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Housewife*9-BIRTHPLACE,
(State or Country),*Md.*

10-NAME OF FATHER,

*John William Kraemer*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore City*

12-MAIDEN NAME OF MOTHER

*Wilhelmina Hemmings*13-BIRTHPLACE OF MOTHER
(State or Country),*Baltimore City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

John W. Kraemer

(Address),

3317 Fleet St.

15-

Filed

APR 4 - 1920

ROBERT E. KAUTER

101...Baptist...Death

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 1st 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *April 1st 9 am* 1920, to *April 1st 10 am* 1920, that I saw her alive on *April* 1920, and that death occurred, on the date stated above, at *5:15 P.M.*

The CAUSE OF DEATH* was as follows:

*Lobar Pneumonia*from *lung* (Duration) yrs. mos. ds. *3 days*
CONTRIBUTORY (Secondary)(Signed) *Loab. M. M. M.* M. D.
April 2, 1920 (Address) *103 S. Baltimore Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Oak Lawn Cem.

DATE OF BURIAL

April 1st 1920

20-UNDERTAKER

Lily & Co. Ziehl

ADDRESS

403 S. Wolfe

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D41945

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

D41945

PLACE OF DEATH

CITY OF BALTIMORE, (No. 952 Harlem Ave.)

ST.:

WARD:

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Meta C. Quandt

(Residence in Baltimore: No. 952 Harlem Ave.)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female
4-COLOR OR RACE, white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, Dec. 29, 1855
(Month) (Day) (Year)

7-AGE, 64 yrs., 3 mos., 4 ds.
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Hair Dresser
(b) General nature of industry, business, or establishment in which employed (or employer), 086

9-BIRTHPLACE, (State or Country), Balto.

10-NAME OF FATHER, Chas. Quandt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Sophia Seng

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Celia Quandt

(Address) 952 Harlem Ave.

APR 4 - 1920 ROBERT E. KAUTEK

Filed, 191.. Borial Permit 01070 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 3, 1920, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Edw. J. M. D.

(Coroner)

191... (Address) 910 E. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Chesapeake Cem. April 6, 1920

20-UNDERTAKER, ADDRESS

W. J. Fischer, 100 North Park

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41946

CERTIFICATE OF DEATH.

150 D41946

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 & Washington ST.; V WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Frank(Residence in Baltimore: No. 124 & Washington St.; yrs., mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

March 14, 1920

(Month)

(Day)

(Year)

7-AGE,

22 yrs., mos., ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),Balto Md

10-NAME OF FATHER,

Ernest Frank11-BIRTHPLACE OF FATHER
(State or Country),Germany

12-MAIDEN NAME OF MOTHER

Gennie Sanger13-BIRTHPLACE OF MOTHER
(State or Country),Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Frank(Address) 124 & Washington

15-APR 4 - 1920

Filed..... 191.....

ROBERT B. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 3, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

3/18/20 191... to 4/3/20 191...that I saw him alive on 3/25/20 191...and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Spine Rigid

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) H. Redmond M. D.4/3/20, 191... (Address) 124 & Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Mary's CemeteryApril 5, 1920

20-UNDERTAKER

ADDRESS

James J. Stott 36 W. Luzerne36 W. Luzerne

Important. See instructions on back of certificate.

D41948

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D41948

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johna Hopkins Hosp. ST. 5* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Maria Danzanski*(a) RESIDENCE. NO. *411 Asguth St.* WARD. *12th*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2 yrs.* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *Jan 21-1896*7 AGE *24* Years *2* Months *13* Days If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Caf. Butler*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Maryland* (State or country)10 NAME OF FATHER *Simon Danzanski*11 BIRTHPLACE OF FATHER (city or town) *Russia* (State or country)12 MAIDEN NAME OF MOTHER *Ida Khran*13 BIRTHPLACE OF MOTHER (city or town) *Russia* (State or country)14 Informant *Hospital Record* (Address)15 *APR 4 - 1920* *ROBERT F. KRAUTER*

Burial Permit (Class)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 3 1920*17 I HEREBY CERTIFY, That I attended deceased from *Jan 25*, 1920, to *April 3, 1920*, that I last saw him alive on *April 3, 1920*, and that death occurred, on the date stated above, at *3:40 A. M.*

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency following rheumatic endocarditis.(duration) *16* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of —Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Dr. Wm. F. Pauloff* J. M. D. *4/3, 1920* (Address) *F. H. N.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Hebron Cemetery**4/4 1920*

20 UNDERTAKER

ADDRESS

*Jack Lewis**1411 E. Calhoun*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D41949

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant
(Address)

15

APR 5 - 1920

ROBERT B. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 20

17

I HEREBY CERTIFY, That I attended deceased from

9-9, 19 19, to 4-2, 19 20

that I last saw him alive on 4-1, 19 20

and that death occurred, on the date stated above, at 4:35 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Contributory (Secondary) Pulmonary embolism (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No special test

(Signed) J. F. Russell, M. D.

4-2, 19 20 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

National Cem.

April 5, 1920

20 UNDERTAKER

ADDRESS 1735

Mrs Robert A. Elliott

Ashears

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D41950

CERTIFICATE OF DEATH.

79 D41950
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2784 W. North Ave ST.; 15 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2784 W. North Ave St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Widow

6-DATE OF BIRTH,

July 25, 1845
(Month) (Day) (Year)

7-AGE,

74 yrs. 8 mos. 9 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

Philip Stern

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Elise Hartman

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oliver Whitehill

(Address) 2784 W. North Ave

15-

Filed

APR 5 - 1920

ROBERT B. KRAUTER

Burial Form No. 1000

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 3rd, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 1, 1920, to April 3rd, 1920,

that I saw her alive on April 2nd, 1920,

and that death occurred, on the date stated above, at 4:15 m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Senility

(Duration) yrs. mos. ds.

(Signed) Chas Jones M. D.

April 3rd, 1920 (Address) 2802 Roslyn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Hebrew

DATE OF BURIAL,

April 5th, 1920

20-UNDERTAKER

J Ahrens & Co

ADDRESS

1611 mad

and

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2141 W. Balto ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary J. M. Cambridge

(a) RESIDENCE. NO.

2141 W. Balto ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 55 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofDennis M. Cambridge

6 DATE OF BIRTH (month, day, and year)

June 1 1829

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.8010

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workat home(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Ireland

10 NAME OF FATHER

Don't know11 BIRTHPLACE OF FATHER (city or town)
(State or country)Ireland

12 MAIDEN NAME OF MOTHER

Ann Rooney13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Ireland

14

Informant
(Address)Elena Martin
2141 W. Balto

15

Filed

APR 5 - 1920ROBERT E. LAUTER
RegistrarBaptist Church

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 1st 1920

17

I HEREBY CERTIFY, That I attended deceased from
Feb. 13, 1919, to March 31st, 1920,
that I last saw her alive on March 31st, 1920.and that death occurred, on the date stated above, at 730 pm m.

The CAUSE OF DEATH* was as follows:

ArteriosclerosisIndefinite (duration) 2 yrs. mos. ds.CONTRIBUTORY
(Secondary)apoplexy
(duration) 2 mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Blood pressure
hypertension
(Signed) B. Kader M. D.

, 19 (Address)

252 N. Bayshore*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral CemApril 5 1920

20 UNDERTAKER

ADDRESS

F. A. France & Son703 N. ...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D41952

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41952

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.:

WARD)

2-FULL NAME

Dorothy Williams

(a) RESIDENCE. NO.

2634 Boone St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

40 yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

1

6 DATE OF BIRTH (month, day, and year)

1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

70

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Luther James

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

?

14

Informant (Address)

Richard Elliott
Philadelphia Pa

15

Filed

APR 5 - 1920

ROBERT R. TRAUBER

Burial Permit 0122

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/3

1920

17

I HEREBY CERTIFY, That I attended deceased from

8 29, 1920, to

4 - 3, 1920

that I last saw him alive on

4 - 3, 1920

and that death occurred, on the date stated above, at

3 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 2 yrs. 7 mos. 3 ds.

CONTRIBUTORY (Secondary)

Chronic diffuse nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

Lawrence S. M. D.

19 (Address)

City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lanel Cmt.

4/6

1920

20 UNDERTAKER

Wm. Cook

ADDRESS

502 E. North

D41953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

D41953

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST.:

WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

APR 5 1920

ROBERT I. KRAUTER
Registrar
Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Oct 1919, 19, to April 3, 1920,

that I last saw him alive on April 3, 1920,

and that death occurred, on the date stated above, at 8 PM.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Allen, M. D.

, 19 (Address) 1227 Calverton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral

4/7 1920

20 UNDERTAKER

ADDRESS

William Cook

5026 North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Schweitzer
HEALTH DEPARTMENT—CITY OF BALTIMORE

D41954

CERTIFICATE OF DEATH.

10 ✓ D41954
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2134 So. Charles

ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2134 So. Charles

St. hys. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

Oct 27, 1919
(Month) (Day) (Year)

7-AGE,

5 yrs. 7 mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Balto Md

10-NAME OF FATHER,

Robert C. Schweitzer

11-BIRTHPLACE OF FATHER
(State or Country),

Balto Md

12-MAIDEN NAME OF MOTHER

Ruth D. Beadles

13-BIRTHPLACE OF MOTHER
(State or Country),

Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Robert C. Schweitzer
1724 S. Charles St.

15-

APR 5 - 1920

Filed

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

4/4/20, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

3/29/20 191, to 4/4/20 191,
that I saw h alive on 4/3/20 191,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Dysentery

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. B. Fowler M. D.

4/4/20, 191... (Address) 1432 William St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.
If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill Cem

DATE OF BURIAL,

April 5, 1919.

20-UNDERTAKER

E. Lehman & Son

ADDRESS

1039

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 lks.

D41955

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41955

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2567 W Balto ST.; 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H Friese

(a) RESIDENCE. No. 2567 W Balto ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of

WIFE of

Hettie O Friese

6 DATE OF BIRTH (month, day, and year) 1865 April 18

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54

11

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

Employed

(c) Name of employer

American Barber Co

9 BIRTHPLACE (city or town) (State or country)

Hagerstown Md.

10 NAME OF FATHER

John Friese

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

Hettie O Friese 2567 W Balto St.

15

APR 5 - 1920

ROBERT E. KRAUTER Registrar

Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 3, 1920

17

I HEREBY CERTIFY, That I attended deceased from

17 hours, 1920, to 3:40 April, 1920,

that I last saw him alive on 2 April, 1920,

and that death occurred, on the date stated above, at 9:00 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy cerebral.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Arteriosclerosis, Hypertension

(duration) 7 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. H. Campbell, M. D.

19 (Address) # 11 K Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery

April 6 1920

20 UNDERTAKER

ADDRESS

W. M. Rountree

2238 North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41956

CERTIFICATE OF DEATH.

104

D41956

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 S Kenwood Ave ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victor J Luth(a) RESIDENCE. NO. 824 S Kenwood Ave ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Left yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chelci6 DATE OF BIRTH (month, day, and year) Jan 11 - 19207 AGE Years 2 Months 23 Days 13 If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md USA10 NAME OF FATHER Ivan Luth11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)12 MAIDEN NAME OF MOTHER Olava Gulis13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)14 Informant Ivan Luth(Address) 824 S Kenwood Ave

15 APR 5 - 1920 ROBERT E. KAUFER Registrar

Burial Permit 01000

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 192017 I HEREBY CERTIFY, That I attended deceased from April March 20, 1920, to April 5, 1920, that I last saw him alive on April 3, 1920, and that death occurred, on the date stated above, at 7-15 am.

The CAUSE OF DEATH* was as follows:

Dysentery & Enteritis(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? none(Signed) D. W. Jones, M. D.1920 (Address) 1011 P. Oldwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Stamislans CemApril 5 - 1920

20 UNDERTAKER

ADDRESS

Stephen J. Falkowskino 8 Kenwood

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41957

CERTIFICATE OF DEATH.

91 D41957

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 Styles

ST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Louisa Tano

(a) RESIDENCE. NO.

913 Styles

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

July 26 1919

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

8

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Tano, Libria

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Marie Tano

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

Libria Tano

913 Styles

15

Filed

APR 5 - 1920

ROBERT B. KRAVITZ

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 4 1920

17

I HEREBY CERTIFY, That I attended deceased from

4-4-1920, 10 a.m. to 4-4-1920, 2 p.m.

that I last saw her alive on 4-4-1920, 2 p.m.

and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

bronchopneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Ch. Festa

M. D.

, 19 (Address)

410 Pearl St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Vincent

April 5 1920

20 UNDERTAKER

ADDRESS

Wendell Dyfford

378 Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41958

CERTIFICATE OF DEATH.

151✓
D41958
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 838 N. Howard ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Deloras V. Scott(Residence in Baltimore: No. 838 N. Howard St.; ✓ yrs., ✓ mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE, <u>Blk</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <u>Single</u>
6-DATE OF BIRTH, <u>March 23rd</u> , 19 <u>20</u> (Month) (Day) (Year)		
7-AGE, <u>✓</u> yrs., <u>✓</u> mos., <u>12</u> ds.		If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work... <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer)... <u>none</u>		

9-BIRTHPLACE,
(State or Country),Baltimore Md

PARENTS.

10-NAME OF FATHER, <u>Thos. Wright</u>
11-BIRTHPLACE OF FATHER (State or Country), <u>Virginia</u>
12-MAIDEN NAME OF MOTHER <u>Raemie Scott</u>
13-BIRTHPLACE OF MOTHER (State or Country), <u>Virginia</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raemie Scott(Address) 838 N. Howard St

15-

APR 5 - 1920

ROBERT B. KLEANTER

Filed

191

BIRTH RECORD

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 4th, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from March 29 1920, to April 4 1920, that I saw her alive on March 29th 1920, and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration).... yrs..... mos..... ds.

CONTRIBUTORY.
(Secondary)

(Duration).... yrs..... mos..... ds.

(Signed) J. B. Luskoch M. D.Apr 4, 1920 (Address) 12 A. A. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.... yrs..... mos..... ds. In the State.... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Wt. Auburn

DATE OF BURIAL,

4-5, 1920

20-UNDERTAKER

John H. Loder

ADDRESS

1443

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D41959

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2130 W. Fayette

ST.: 20 WARD)

2-FULL NAME Augustus Winters

(a) RESIDENCE. No. 2130 W. Fayette

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

Margaret Winters

6 DATE OF BIRTH (month, day, and year)

July 2 - 1857

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

62

9

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

foreman

(b) General nature of industry, business, or establishment; in which employed (or employer)

Street repairs

(c) Name of employer

Baltimore City

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Anton Winters

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Lydia Lamp

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

Margaret Winters

(Address)

2130 W. Fayette St.

15

Filed

APR 5 - 1920

ROBERT E. ELAUTER

Registrar

Burial Permit 0107

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1920

17

I HEREBY CERTIFY, That I attended deceased from

October 1st 1919 to April 3 1920

that I last saw him alive on March 30 1920

and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

if not at place of death?

unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed)

Chester Kiland,

M. D.

4-4, 1920 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

April 6 1920

20 UNDERTAKER

ADDRESS

John J. Fields 1200 W. Lombard

D41960

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4102 Ridgewood St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 4102 Ridgewood St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Mar. 8, 1920
(Month) (Day) (Year)

7-AGE,

27 yrs. 2 mos. 27 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, business,
or establishment in which
employed (or employer).....None9-BIRTHPLACE,
(State or Country),Mo.10-NAME OF
FATHER,Robert Stafford Jr.11-BIRTHPLACE
OF FATHER
(State or Country)Philadelphia Pa.12-MAIDEN NAME
OF MOTHERNortha Pfeiffer13-BIRTHPLACE
OF MOTHER
(State or Country),Philadelphia Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Robert Stafford

(Address)

3402 Clifton Ave.

15-

APR 5 - 1920

ROBERT H. KRAUTER

101 E. Pratt St. Permit 01121 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Apr. 4, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 31, 1920, to Apr. 4, 1920,that I saw him alive on Apr. 3, 1920,and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Iles Colitis

.....

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)Broncho Pneumonia

..... (Duration)..... yrs..... mos..... ds.

(Signed) W.S. Hiblett M. D......, 191... (Address) 3402 Clifton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Woodlawn Cem.April 6, 1920

20-UNDERTAKER

ADDRESS

For Frederickson217 S. Penn

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D41961

151 D41961

PLACE OF DEATH

CITY OF BALTIMORE (No. 1656 Street

2-FULL NAME Mrs. Pikel

(Residence in Baltimore: No. 1656 Street

ST.: 2

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, April 4, 1920

7-AGE, 46 yrs., mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, none

(b) General nature of industry, business, or establishment in which employed (or employer), none

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Vincent Pikel

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Genoveva Kurkawa

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Vincent Pikel

(Address) 1656 Street

15-

Filed.

APR 5 - 1920

ROBERT E. KRAUTER

Notary Public

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 4, 1920

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congestive heart failure

CONTRIBUTORY (Secondary)

(Signed) Henry L. F. M. D. 4/5, 1920 (Address) 1610 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, April 5, 1920

20-UNDERTAKER, William Lialfowick, 148 Eastern

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21-20-25-15 ST.: 12 WARD)2-FULL NAME Maudain McClees Ashbrook(a) RESIDENCE. No. 21-20-25-15 ST. 12 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 17 yrs. 8 mos. 21 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(Resident)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)6 DATE OF BIRTH (month, day, and year) July-11-19027 AGE Years 17 Months 8 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Dr. Wm. B. Ashbrook11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington Penna.12 MAIDEN NAME OF MOTHER Lillian McClees13 BIRTHPLACE OF MOTHER (city or town) (State or country) Columbia South Carolina14 Informant Dr. W. B. Ashbrook - (Father) (Address) 21-20-25-Street15 File APR 5 - 1920 ROBERT B. KRAUTER Registrar Serial Permit 0144

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/2/192017 I HEREBY CERTIFY, That I attended deceased from Jan 8/12, 1920, to Apr 2nd, 1920, that I last saw him alive on Apr 2nd, 1920, and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial NephritisCONTRIBUTORY (Secondary) Probably a similar attack (duration) 3 yrs. 3 mos. 3 ds. three years ago18 Where was disease contracted if not at place of death? Wilmington DelawareDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Urine + blood (Signed) Geo H. Cairnes, M. D.19 (Address) 21-20-25-Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Western Cemetery Apr 5/192020 UNDERTAKER STEWART & MOWEN COMPANY ADDRESS 108 W. NORTH AVE. (WILLIAM F. WOODEN, Successor)

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH
County Baltimore

Village or City Baltimore

(No. 1217 Mullikin St.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration District No. 5

Ward 92

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Henry Primus

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE col. 5 SINGLE MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH 1875
(Month) (Day) (Year)

7 AGE 45 yrs. mos. ds. 11 LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Laborer (b) General nature of industry business, or establishment in which employed (or employer) 040

9 BIRTHPLACE (State or country) Unknown

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Wm. Bond

(Address) 1217 Mullikin St

15 APR 5 - 1920 ROBERT H. KRAUTER
Burial Permit Glendon

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 2nd, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 25th, 1920, to April 2nd, 1920, that I last saw him alive on April 2nd, 1920, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH * was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds. 3
Contributory Yellow Jaundice
Secondary

(Duration) yrs. mos. ds. 6
(Signed) J. A. Thomas M.D.

April 2, 1920 (Address) 818 2nd St. Sparrow
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. mos. ds. in the State, 1 yrs. mos. ds.
Where was disease contracted, 1217 Mullikin St
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Lanier Cem. DATE OF BURIAL April 5, 1920

20 UNDERTAKER Mrs. J. G. Locks ADDRESS 1302 Jefferson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41965

D41965

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *S.W. Cor Fulton Ave & Franklin* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Home for the Aged of the M. E. Church* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married* (Write the word.)6-DATE OF BIRTH, *unknown*, 1844 (Month) (Day) (Year)7-AGE, *76* yrs. mos. ds. If LESS than 1 day, ...hrs. or...min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Retired* (b) General nature of industry, business, or establishment in which employed (or employer). *Housewife*9-BIRTHPLACE, (State or Country), *ind.*10-NAME OF FATHER, *unknown*11-BIRTHPLACE OF FATHER (State or Country), *unknown*12-MAIDEN NAME OF MOTHER *unknown*13-BIRTHPLACE OF MOTHER (State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss E. R. Newshaw*(Address) *700 E. Home for Aged*

15-APR 5 - 1920. ROBERT A. LAUTER Filed 191. Social Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 3*, 19*20*. (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Feb 3* 19*20*, to *Apr 3* 19*20*, that I saw her alive on *April 3* 19*20*, and that death occurred, on the date stated above, at *10:15* p. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic (Duration) *2* yrs. *✓* mos. *✓* ds.CONTRIBUTORY *Bronchitis Acute* (Secondary)(Signed) *George C. Shannon* M. D. *4/5*, 19*20* (Address) *700 Fulton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D41966

78-1966
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *321 S. Collington Ave* St.; *25* WARD)

2-FULL NAME

(Residence in Baltimore: No. *321 S. Collington Ave* St.; *25* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE,

Married

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

March 12, 1868
(Month) (Day) (Year)

7-AGE,

52 yrs. 0 mos. 22 ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House wife

9-BIRTHPLACE, (State or Country),

Poland

10-NAME OF FATHER,

Tomas Glichka

11-BIRTHPLACE OF FATHER (State or Country),

Poland

12-MAIDEN NAME OF MOTHER

Mary Wajcik

13-BIRTHPLACE OF MOTHER (State or Country),

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wladyslaw Kozik*(Address) *321 S. Collington Ave*

15-APR 5 - 1920

ROBERT A. KRAUTER

Filed..... 191..... Burial. Pl. *St. Mary's* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 3, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

*March 15, 1920, to April 3, 1920,*that I saw h *2* alive on *April 2, 1920,*and that death occurred, on the date stated above, at *7 a* m.

The CAUSE OF DEATH* was as follows:

Acute Valvular Heart Disease

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute Coronary Disease

(Duration)..... yrs. mos. ds.

(Signed) *W. J. R. [Signature]* M. D.*4/3/20* (Address) *St. Mary's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

18-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Rosary Cemetery April 6, 1920.

20-UNDERTAKER

ADDRESS

Edmund W. Conklin 924 E. [Address]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Joseph Ostapink.

D41967

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104-091 ✓
D41967
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *532 S. Ann*)

ST.: *2* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Joseph Ostapink*

(a) RESIDENCE. NO. *532 S. Ann*

ST., *2* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *10* mos. *23* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 12/1914*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
0 10 23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *child.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.*
(State or country)

10 NAME OF FATHER *John Ostapink.*

11 BIRTHPLACE OF FATHER (city or town) *Russia*
(State or country) *Poland.*

12 MAIDEN NAME OF MOTHER *Mary Gsalk.*

13 BIRTHPLACE OF MOTHER (city or town) *German*
(State or country) *Poland.*

14 Informant *John Ostapink.*
(Address) *#532 S. Ann St.*

15 *APR 5 - 1920* *ROBERT H. TRAUTER*
Basis Permit *OSTA*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 4 1920*

17 I HEREBY CERTIFY, That I attended deceased from *March 25*, 19*20*, to *April 4*, 19*20*, that I last saw him alive on *April 3*, 19*20*, and that death occurred, on the date stated above, at *9 A* m. The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. *10* ds.

CONTRIBUTORY *Brain Pneumonia & Heart failure*
(Secondary)

(duration) yrs. mos. *2* ds.

18 Where was disease contracted *Home*
if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Symptoms*
(Signed) *W. A. Dreibitz*, M. D.
, 19*20* (Address) *1623 E. North Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Holy Rosary.* DATE OF BURIAL *APR 5 - 1920*

20 UNDERTAKER *M. F. Sadowski.* ADDRESS *405 S. Ann*

Sidaika

RE 89 ✓
D41968
REGISTERED NO. C

REGISTERED NO. C

CITY OF BALTIMORE: (No. 125 alternate ST. 2 WARD)

Stephen Schindler - (Sidaika)

(Residence in Baltimore: No. 125 E. Maryland — St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

MEDICAL CERTIFICATE OF DEATH.

3-SEX, *m* 4-COLOR OR RACE, *W* 5-SINGLE, *Single*
MARRIED, ☒ WIDOWED, ☐
OR DIVORCED, ☐
(Write the word.)

6-DATE OF BIRTH, March 4, 1920
(Month) (Day) (Year)

7-AGE,yrs. /mos. /ds. If LESS than 1 day,hrs. or.....min?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER. *Stefan S. S. S.*

11-BIRTHPLACE
OF FATHER

12-MAIDEN NAME
OF MOTHER

13-BIRTHPLACE
OF MOTHER

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. L. H. 1.1... R. L. ...

(Address) 125... a... ..

15- ROBERT B. BRADY

Filed..... 191.....

16-DATE OF DEATH, April 5 — 1980
..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
April 2 19120, to April 5 19120,
 that I saw him alive on April 4 19120,
 and that death occurred, on the date stated above, at 7 a m.
 The CAUSE OF DEATH* was as follows:

Capillary Buckets

..... (Duration)..... yrs..... mos. 0 da.
CONTRIBUTORY..... Carpine & Wash
(Secondary).....

..... (Duration).....yrs.....mos.....da.

(Signed).....*D. R. E. Tucker*.....M. D.

41125 19120 (Address) 125 S. Main —

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence

10-PLACE OF BURIAL OR REMOVAL.

Half Redeemer April 6 1912

20-UNDERTAKER	ADDRESS
---------------	---------

John G. K. Liukas 425 S. Park St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41969

D41969

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1522 E Eager St*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1522 E Eager St*)St. *Lf* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

August 3, 1895
(Month) (Day) (Year)

7-AGE,

24 yrs. 8 mos. 1 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *House Work*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Maryland

10-NAME OF FATHER,

Elijah M. Martin

11-BIRTHPLACE OF FATHER (State or Country).

Baltimore

12-MAIDEN NAME OF MOTHER

Laura A. Harrigan

13-BIRTHPLACE OF MOTHER (State or Country).

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Laura M. Merkle*(Address) *6300 Full St*

15-

APR 5 - 1920

ROBERT I. KRAUTER

Filed

191

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 4, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Jan 1, 1920, to April 4, 1920,*that I saw him alive on *April 3, 1920,*and that death occurred, on the date stated above, at *9 A* m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Intermittent
Duration yrs. mos. ds.

CONTRIBUTORY (Secondary)

Shunt yrs. mos. ds.(Signed) *R. P. Campbell* M. D.*April 4, 1920* (Address) *1644 N. Howard St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Woodlawn Cemetery *April 7, 1920*

20-UNDERTAKER

ADDRESS

Henry Lutz *1007 N. Bond St*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. THIS STATEMENT OF OCCUPATION IS VERY important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41970

CERTIFICATE OF DEATH.

150 D41970
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1854 N. Gay

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Raymond Paul Walker*

(Residence in Baltimore: No. 1854 N. Gay

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

April 3, 1920
(Month) (Day) (Year)

7-AGE,

1 1/2 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,
(State or Country),*Balto. Md.*

10-NAME OF FATHER,

*Wm. E. Walker*11-BIRTHPLACE OF FATHER
(State or Country),*Balto. City*

12-MAIDEN NAME OF MOTHER

*Clara Kowitz*13-BIRTHPLACE OF MOTHER
(State or Country),*Balto. City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edwin B. Fenby*(Address) *1223 N. Caroline St.*

15-

APR 5 - 1920

ROBERT R. KAUTER

BUYER PERMIT OFFICE
Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 5, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Apr. 3, 1920*, to *Apr. 5, 1920*, that I saw him alive on *April 4, 1920*, and that death occurred, on the date stated above, at *7 A. M.*

The CAUSE OF DEATH* was as follows:

Defective development of heart. Blue baby.
(Duration) yrs. mos. *1 1/2 ds.*CONTRIBUTORY
(Secondary)(Duration) yrs. mos. *1 1/2 ds.*(Signed) *Edwin B. Fenby, M. D.**Apr. 5, 1920* (Address) *1223 N. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Holy Cross Cemetery

DATE OF BURIAL,

4/5/1920

20-UNDERTAKER

ADDRESS

B. J. Manning 1958 E. Lexington

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41971

CERTIFICATE OF DEATH.

122 D41971
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Homan's Hospital* ST. *1* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2944 Hudson* St.; *10* yrs., *0* mos., *0* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.) *Married*

6-DATE OF BIRTH.

Oct 30, 1881
(Month) (Day) (Year)

7-AGE.

*38 yrs. 5 mos. 4 ds.*If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*9-BIRTHPLACE,
(State or Country),*Washington D.C.*

PARENTS.

10-NAME OF FATHER.

*William Myers*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore Md.*

12-MAIDEN NAME OF MOTHER

*Johanna Newman*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jacob Sause*(Address) *2944 Hudson St.*

15-

Filed

APR 5 - 1920

ROBERT R. KAUTER

BUTLER PRINTING CO. BALTIMORE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 4, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *March 4, 1920*, to *April 4, 1920*, that I saw her alive on *April 4, 1920*, and that death occurred, on the date stated above, at *12³⁰ a.m.*

The CAUSE OF DEATH* was as follows:

Pyemia

(Duration).....yrs...1...mos...20...ds.

CONTRIBUTORY (Secondary)

Bilateral Pneumonia Obscure
(Duration).....yrs...0...mos...30...ds.
(Signed) *J. S. Speed* M. D.
Apr. 4, 1920 (Address) *Homan's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos...30...ds. In the.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Oak Lawn

DATE OF BURIAL,

April 2, 1920

20-UNDERTAKER

H. Sander Dow

ADDRESS

1710 N. 1st St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D41972

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41972

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3421 Myrtle Place ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Heitzel(a) RESIDENCE. No. 3421 Myrtle Place ST. 26 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of Wilhelmina Heitzel (or) WIFE of6 DATE OF BIRTH (month, day, and year) Oct 1 - 18847 AGE Years 75 Months 6 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Karl Heitzel11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Not Known13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known14 Informant Mrs. Thomas Dordon (Address) 3421 Myrtle Place15 APR 5 - 1920 ROBERT B. KAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3/20 1917 I HEREBY CERTIFY, That I attended deceased from Dec, 1919, to Apr 3, 1920, that I last saw him alive on Apr 3, 1920, and that death occurred, on the date stated above, at 4:50 P. m. The CAUSE OF DEATH* was as follows:Ascending Pulmonary
Ordinary (duration) yrs. mos. ds.
CONTRIBUTORY Chronic Intestitis
Secondary (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wright S. Dudley, M.D.
4/1/20 Address 3523 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

1st Evangelical Cem.April 6 1920

20 UNDERTAKER

ADDRESS

H. Sander Sons1210 Reisterstown Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 S. Hallar)ST. 3 WARD)2-FULL NAME Steve Rose(a) RESIDENCE. NO. 106 S. Hallar(Usual place of abode)
Length of residence in city or town where death occurred

yrs.

mos. 10

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Days

If LESS than
1 day. hrs.
or min.

7 AGE

Years

Months

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)10 NAME OF FATHER Ernest Rose11 BIRTHPLACE OF FATHER (city or town)
(State or country)12 MAIDEN NAME OF MOTHER Rose13 BIRTHPLACE OF MOTHER (city or town)
(State or country)14 Informant
(Address)15 APR 5 - 1920ROBERT E. KRAUTER
Registrar

Burial Permit 01033

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5th 192017 I HEREBY CERTIFY, That I attended deceased from
April 5th 1920 to April 5th 1920
that I last saw him alive on April 5th 1920
and that death occurred, on the date stated above, at 8 a. m.The CAUSE OF DEATH* was as follows:
malnutritionCONTRIBUTORY (duration) yrs. mos. ds.
Conjunctive stenosis of
(Secondary) cardiac end of stomach. yrs. mos. ds.
(duration)18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical Exam. only

(Signed)

4/5, 1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Wood Lawn4-5

1920

20 UNDERTAKER

H. Sander & Sons 1710 Mt. AiryShould state
of OCCUPA-
tion should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41974

CERTIFICATE OF DEATH.

104
D41974
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 Green ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Lentines(Residence in Baltimore: No. 407 Green St.; 1 yrs., 5 mos., 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, single (Write the word.)6-DATE OF BIRTH Oct 12, 1918
(Month) (Day) (Year)7-AGE, 1 yrs., 5 mos., 28 ds. If LESS than 1 day, ...hrs. or...min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer)...9-BIRTHPLACE, (State or Country), Baltimore City10-NAME OF FATHER, Joseph Lentines11-BIRTHPLACE OF FATHER (State or Country), Italy12-MAIDEN NAME OF MOTHER, Gracifila13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joe Lentines(Address) 407 Green St.15-
APR 5 - 1920

Filed....., 191..... ROBERT J. KRANTZ

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4-4-1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from 3-3-1920, to 4-4-1920, that I saw him alive on 4-4-1920, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of the lung
.....
..... (Duration).....yrs.....mos.....ds.CONTRIBUTORY.....
(Secondary).......... (Duration).....yrs.....mos.....ds.
(Signed)..... M. D.
4-5-1920 (Address) 1004 1/2

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

CathedralApril 6, 1920

20-UNDERTAKER

ADDRESS

Arthur Fahy & Sons 1827 North St.

Physician's should state cause of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41975

CERTIFICATE OF DEATH.

113 D41975
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 Woodley ST.; 16 WARD)2-FULL NAME Philip S. Shen(Residence in Baltimore: No. 907 Woodley St.;

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male4-COLOR OR RACE. White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH. Nov 27, 1878

(Month)

(Day)

(Year)

7-AGE. 41 yrs. 4 mos. 7 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Bar tender

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Richard J. Shen11-BIRTHPLACE OF FATHER (State or Country), Ireland12-MAIDEN NAME OF MOTHER Catherine White13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo J. Setz(Address) 1124 W. Hanbury

15-

Filed APR 5 - 1920

191.

ROBERT H. KRAUTER

Bureau of Registration

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 3, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1920, to April 3, 1920,that I saw him alive on April 2, 1920,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) W. A. Neill M. D.April 4, 1920 (Address) 108 N. Patterson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL, April 6, 1920Cathedral Cemetery

20-UNDERTAKER

ADDRESS

James J. Dignan 1000 S. Peck St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41976

CERTIFICATE OF DEATH.

120 D41976
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 N. Lombard ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 924 N. Lombard St. St.; 60 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH,

Jan 28, 1874
(Month) (Day) (Year)

7-AGE,

76 yrs., mos., ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).House
work9-BIRTHPLACE,
(State or Country),Ireland

10-NAME OF FATHER,

Wm. P. Patton11-BIRTHPLACE OF FATHER
(State or Country),Md.

12-MAIDFN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or Country),Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Edgar R. Young(Address) 924 N. Lombard St.

15-

Robert P. Harrison,

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 4, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 12, 1912, to April 4, 1912,that I saw him alive on April 3, 1912,and that death occurred, on the date stated above, at 7 45 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(Duration) 3 yrs., mos., ds.CONTRIBUTORY
(Secondary)(Duration) yrs., mos., ds.(Signed) John H. Harrison M. D.414 E. 101 (Address) 888 N. Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Louisa St.

DATE OF BURIAL

April 11, 1912

20-UNDERTAKER

John H. Harrison

ADDRESS

924 N. Lombard St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D41977

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C.

PLACE OF DEATH

CITY OF BALTIMORE (No. 111 Welcome Alley.

ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Bright.(C).

(Residence in Baltimore: No.

111 Welcome Alley.

40.-----
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female.

4-COLOR OR RACE,

Colored.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Widow.

6-DATE OF BIRTH,

Do not know, 1
(Month) (Day) (Year)

7-AGE,

58 yrs.-----mos.-----ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

None.

9-BIRTHPLACE,

(State or Country),

Virginia.

10-NAME OF FATHER,

Do not know.

11-BIRTHPLACE OF FATHER (State or Country),

Do not know.

12-MAIDEN NAME OF MOTHER

Do not know.

13-BIRTHPLACE OF MOTHER (State or Country),

Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Brickers.(C).

(Address) 111 Welcome Alley.

15-

APR 5 - 1920

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 4th, 1920, 191
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

April 5th, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

1111 Broadway St 108 W. Mount St

D41978

HEALTH DEPARTMENT—CITY OF BALTIMORE

37 D41978

1-PLACE OF DEATH *Bay View Hospital*

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.: *26* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *William Scott*

(Residence in Baltimore: No. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*Black*5-SINGLE, *Single*~~MARRIED,~~
~~WIDOWED,~~
~~OR DIVORCED,~~
(Write the word.)

6-DATE OF BIRTH,

1890 March 17, 1920
(Month) (Day) (Year)

7-AGE

30

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

9-BIRTHPLACE, (State or Country),

Unknown

10-NAME OF FATHER,

Do.

11-BIRTHPLACE OF FATHER (State or Country),

Do.

12-MAIDEN NAME OF MOTHER

Do.

13-BIRTHPLACE OF MOTHER (State or Country),

Do.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Bay View Hospital
Baltimore, Md.

15-

Robert F. Harrison,

Filed

APR 5 - 1920

191

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 2, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

*March 17, 1920, to April 1, 1920,*that I saw him alive on *April 1, 1920,*and that death occurred, on the date stated above, at *12:00 a.m.*

The CAUSE OF DEATH* was as follows:

General Paralysis (of the insane).

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. J. Harrison**4/3/20* (Address) *Bay View Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. *15* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Do.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

17081

APR 5 1920

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-2-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D41979

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST.: *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Theodore Parker*

(a) RESIDENCE. No. *222 Myrtle Ave* ST.: *12th* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *2* mos. *11* ds. How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Child*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Child*

6 DATE OF BIRTH (month, day, and year) *Jan 30 - 1920*

7 AGE Years *2* Months *11* Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md* (State or country)

10 NAME OF FATHER *Harry Harris*

11 BIRTHPLACE OF FATHER (city or town) *Md.* (State or country)

12 MAIDEN NAME OF MOTHER *Frances Parker*

13 BIRTHPLACE OF MOTHER (city or town) *Md.* (State or country)

14 Informant *Hospital Record* (Address) *H. 26*

15 *Robert F. Harrison,*

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 31 1920*

17 I HEREBY CERTIFY, That I attended deceased from *March 29, 1920, to March 31, 1920.*

that I last saw him alive on *March 31, 1920.*

and that death occurred, on the date stated above, at *3:50* m.

The CAUSE OF DEATH* is as follows:

Measles

CONTRIBUTORY (Secondary) *Bronchopneumonia* (duration) yrs. mos. *4* ds.

18 Where was disease contracted if not at place of death? *Patient's home*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Clinical + autopsy* (Signed) *W. H. H. J. H. H.* M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

Commissioner Health.

W. W. E. WOODALL

APR 5 - 1920

APR 5 1920

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

041980

HEALTH DEPARTMENT—CITY OF BALTIMORE

041980

CERTIFICATE OF DEATH.

X 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. ST.*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Isaac F. Roman*

(a) RESIDENCE. No. *Edenville Franklin Pa.* ST.

WARD. *12 M*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *unknown* yrs. *2* mos. *2* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

54 Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Quarry Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country) *Edenville Franklin Pa.*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town, State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town, State or country)

14

Informant (Address)

H. Capital Record H. H.

15

Filed

19 *Robert B. Harrison*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *March 30 1920*

17

I HEREBY CERTIFY, That I attended deceased from *March 28, 1920, to March 30, 1920,* that I last saw him live on *March 30, 1920,* and that death occurred, on the date stated above, at *2:42* m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta & aneurysm of ascending aorta

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*

Was there an autopsy? *No*

What test confirmed diagnosis? *—*

(Signed) *W. H. Harrison, M. D.*

, 19 (Address) *D. H. H.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITAL

20 UNDERTAKER

Commissioner Health,

ADDRESS

Wm. K. WOODALL

APR 5 - 1920

Burial Permit

D41981

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41981

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Littner

(a) RESIDENCE. No. Unknown

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of		
6 DATE OF BIRTH (month, day, and year) 1835		
7 AGE	Years	Months Days
85		If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Virginia (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Rosa Johnson Mar. 31, 1920 (Address) New City Hospital.

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant Hospital Records (Address) New City Hospital.

15 Filed 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1920

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1920, to March 31, 1920, that I last saw her alive on March 31, 1920, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis - Pneumonia

unknown (duration) yrs. mos. ds. 5?

CONTRIBUTORY acute Pharyngitis; (Secondary) Stomatitis; (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no special test

(Signed) J. P. Perrell M. D.

(Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHN'S HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER 1176 COM W. M. J. M.

ADDRESS

APR 3 1920

PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

APR 5 - 1920

Burial Permit Clerk

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

041982

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Sr. 1 yrs. 8 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

March 12, 1920, to April 5, 1920
that I saw him alive on April 4, 1920
and that death occurred, on the date stated above, at 7:45 a.m.
The CAUSE OF DEATH* was as follows:

Diphtheria - tonsillar.
Measles.

(Duration) yrs. mos. 26 ds.

Contributory (SECONDARY)

(Duration) yrs. mos. 15 ds.

(Signed)

April 5, 1920 (Address) Sydenham Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death - yrs. - mos. 25 ds. In the State yrs. mos. ds.

Where was disease contracted? At home

If not at place of death? Former or usual residence 536 W. Barre St.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

April 5, 1920

20 UNDERTAKER

ADDRESS

J. J. Carey & Sons 318 Light St.

APR 5 - 1920 Robert B. Harrison, REGISTRAR
Burial Permit Clerk

D41983

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41983

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1231 Hollin ST.; 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1231 Hollin St.; 70 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Married

6-DATE OF BIRTH

Aug 4, 1844
(Month) (Day) (Year)

7-AGE

75 yrs., 7 mos., 29 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Trunk maker9-BIRTHPLACE,
(State or Country)Germany

10-NAME OF FATHER

Carl B. Jordan11-BIRTHPLACE OF FATHER
(State or Country)Prussia

12-MAIDEN NAME OF MOTHER

W. J. Kelley13-BIRTHPLACE OF MOTHER
(State or Country)Prussia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Wm. J. Jordan
1231 Hollin St.

15-

Filed 1915 1020 Harrison

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Apr 2, 1915
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mar 20 1915, to Apr 2 1915that I saw him alive on Apr 1-20 1915and that death occurred, on the date stated above, at 5:10 p.m.

The CAUSE OF DEATH* was as follows:

Chorea(Duration) 2 yrs., 0 mos., 0 ds.CONTRIBUTORY
(Secondary)(Duration) 2 yrs., 0 mos., 0 ds.(Signed) Wm. J. Jordan M. D.7/2, 1915 (Address) 1302 N. Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Western Cem7/6, 1915

20-UNDERTAKER

ADDRESS

Wm. J. Papey House318 E. Light St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Burial Permit Clerk.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D41985

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41985

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *917 Bennett Pl.* ST. *18* WARD)

2-FULL NAME

(a) RESIDENCE. (No. *917 Bennett Pl.* ST. *18* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

(yrs. *6*) mos.

ds. How long in U. S., if of foreign birth? *52* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 7 1854*

7 AGE Years *66* Months *7* Days *28* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*

10 NAME OF FATHER *Unknown*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14 Informant (Address) *C. H. Ruff*
917 Bennett Pl.

15 Filed

19

Robert F. Harrison,

Registrar

APR 5 - 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 5* 19*20*

17 I HEREBY CERTIFY, That I attended deceased from *December 18*, 19*17*, to *April 5*, 19*20*.

that I last saw him alive on *April 3*, 19*20*.

and that death occurred, on the date stated above, at *12 noon* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach with Metastasis

(duration) *2* yrs. *6* mos. *—* ds.

CONTRIBUTORY (Secondary)

(duration) *—* yrs. *—* mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *May 15 1914*

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Wm. S. Perkins*, M. D.

4/5, 1920 Address) *107 Franklin St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lorraine

April 8 19*20*

20 UNDERTAKER

ADDRESS

George H. Lillie

5311 Greenmount

Spec. 6-9-19—H. P. Co.—1900 Bks.

138391

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Miss Lucille Taylor*

(a) RESIDENCE. No. *156 Dorr St. Manhattan Beach 29 Ky.* (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred *undetermined* yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April 10 - 1899*

7 AGE Years Months Days If LESS than 1 day. hrs. or min. *20 " 4da*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *housekeeper*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Hackensack* (State or country) *New Jersey*

10 NAME OF FATHER *Alva L. Taylor*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *M.D.*

12 MAIDEN NAME OF MOTHER *Oliver A. Petty*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *M.D.*

14 Informant (Address) *J. H. Harris* *Robert F. Harrison,* Registrar

APR 5 - 1920 Burial Permit Clerk

Wm Adams Express - Co. - Penn. R.R.

REGISTERED NO. *122*

16 DATE OF DEATH (month, day, and year) *4-4-1920*

17 I HEREBY CERTIFY, That I attended deceased from *Jan 7th*, 1920, to *April 4*, 1920, that I last saw her alive on *April 4*, 1920, and that death occurred, on the date stated above, at *10:30 a.m.*

The CAUSE OF DEATH* was as follows: *Pyelonephritis (bilateral).*

(duration) yrs. *14* mos. ds.

CONTRIBUTORY *Ectopy of Bladder* (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of

Was there an autopsy? *yes*

What test confirmed diagnosis? *Autopsy*

(Signed) *H. H. Harris* M. D.

19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Newark - N. J.* DATE OF BURIAL *4/5 1920*

20 UNDERTAKER *Henry W. Means* ADDRESS *805 N. Calvert*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D41987

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Mary Hospital*

REGISTERED No. C

CITY OF BALTIMORE (No.)

ST. *11*

WARD)

2-FULL NAME

Harriet Corning Jones

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1220 Linden Ave*

St.; yrs., *6* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED, *widow*

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

July

28

1898

(Month)

(Day)

(Year)

7-AGE,

82

yrs.

8

mos.

8

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

none

9-BIRTHPLACE,

(State or Country),

Corning New York

10-NAME OF

FATHER,

Shubel Denton

11-BIRTHPLACE

OF FATHER

(State or Country),

not known

12-MAIDEN NAME

OF MOTHER

Shontz

13-BIRTHPLACE

OF MOTHER

(State or Country),

not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *H. S. Hastings*

(Address) *11chester Md.*

15-

Robert P. Harrison,

APR 5 - 1920

191

Burial Permit Cl Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr

5

1918

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said

inquest, au-

topsy or inquiry

on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

accidental

alcohol

Starvation

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY

(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *W. H. H. H.*

(Coroner.)

M. D.

1113 S. 10th (Address) *Corning*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place *see above* In the

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence *Corning N. Y.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Greenmount Cem

April 6, 1920

20-UNDERTAKER

ADDRESS

Henry W. Jones

Orchard

D41988

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41988

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1529 John ST.; 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Earl S. Hollinger Jr
(Residence in Baltimore: No. 1529 John St.; — yrs., — mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.) Single

6-DATE OF BIRTH,

March 28, 1920
(Month) (Day) (Year)

7-AGE,

— yrs., — mos., 8 ds.If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer). ad9-BIRTHPLACE,
(State or Country),Balto, Md.

PARENTS.

10-NAME OF FATHER,

Earl S. Hollinger Sr.11-BIRTHPLACE OF FATHER
(State or Country),Pa.

12-MAIDEN NAME OF MOTHER

Arabelle Fisher13-BIRTHPLACE OF MOTHER
(State or Country),Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl S. Hollinger(Address) 1529 John St.

15-

APR 5 - 1920 191 Robert P. Harrison,
Registrar.Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 5, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from March 28, 1920, to April 5, 1920, that I saw him alive on April 5, 1920, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

unilateral hemorrhage
4 hrs.(Duration) — yrs. — mos. — ds.CONTRIBUTORY
(Secondary)congenital obstruction of bile ducts (Duration) — yrs. — mos. 8 ds.(Signed) Chester Poland M. D.4-5, 1920 (Address) 2532 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Studer Church Pa.

DATE OF BURIAL,

April 5, 1920

20-UNDERTAKER

Wm. Cook

ADDRESS

1529 John St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

11-11-11
X. E.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D41989

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41989

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE, NO. 4th av. Fairfield ST., WARD 27
2-FULL NAME James Spencer
(a) RESIDENCE, NO. 4th av. Fairfield ST., WARD 27
(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS
3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (Write the word) Married
5a If married, widowed, or divorced, state name of HUSBAND or WIFE (or) name of late Spencer
6 DATE OF BIRTH (month, day, and year)
7 AGE 65 Years Months Days If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work High Watchman (b) General nature of industry, business, or establishment in which employed (or employer) Gain How Co (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Spils Co
10 NAME OF FATHER Thomas Spencer
11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland
12 MAIDEN NAME OF MOTHER Cath Hanly
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Robert B. Harrison,
15 Registrar

APR 5 - 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1920
17 I HEREBY CERTIFY, That I attended deceased from Feb. 10 1920, Apr. 3 1920, that I last saw him alive on Apr. 1 1920, and that death occurred, on the date stated above, at 5.30 P. m.
The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

CONTRIBUTORY (Secondary) unburnt Encephalitis

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) Thos. B. Hazen, M. D.
19 (Address) Cedar St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 ADDRESS

21 UNDERTAKER

11-10-1915
139985

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST.: *119* WARD)

2-FULL NAME *Godfrey Klaus.*

(a) RESIDENCE. NO. *805 Dora St.* ST.: *24* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *5 yrs. 24 mos. 24 ds.* How long in U. S., if of foreign birth? *5 yrs. 24 mos. 24 ds.*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of *2*

6 DATE OF BIRTH (month, day, and year) *Nov 14 1868*

7 AGE Years *51* Months *4* Days *24* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work *Laborer* (b) General nature of industry, business, or establishment in which employed (or employer) *040* (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md.*

10 NAME OF FATHER *Godfrey Klaus*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*

12 MAIDEN NAME OF MOTHER *Elizabeth Radzky*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14 Informant (Address) *J.H. Records.*

15 *Robert F. Harrison,* Registrar

16 DATE OF DEATH (month, day, and year) *April 5th 1920*

17 I HEREBY CERTIFY, That I attended deceased from *April 3rd*, 1920, to *April 5*, 1920, that I last saw him alive on *April 5*, 1920, and that death occurred, on the date stated above, at *945 a. m.*

The CAUSE OF DEATH* was as follows:

Acute lobar pneumonia

(duration) *7* yrs. *7* mos. *7* ds.

CONTRIBUTORY (Secondary) (duration) *7* yrs. *7* mos. *7* ds.

18 Where was disease contracted if not at place of death? *no*

Did an operation precede death? *no* Date of *—*

Was there an autopsy? *yes*

What test confirmed diagnosis? *autopsy*

(Signed) *W.B. Bloomfield*, M. D.

19 (Address) *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Lorraine Cemetery* DATE OF BURIAL *April 9 1920*

20 UNDERTAKER *F.B. Neupert 2236 Fred R.*

APR 5 - 1920

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41992

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 Mill Race Road 13 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 1504 Mill Race Road WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 19 1920

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt City

10 NAME OF FATHER Charles Talbott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Lona Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant (Address) Lona Talbott
1504 Mill Race Road

15 Filed APR 6 - 1920 ROBERT R. LEAUTE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Mar 20, 1920, to April 5, 1920, that I last saw him alive on April 3rd, 1920, and that death occurred, on the date stated above, at 12:30 PM. The CAUSE OF DEATH* was as follows:

Organic to the testicles

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. G. Hillish M. D.

Address 1527 Union Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St Marys Hospital Apr 6 1920

20 UNDERTAKER ADDRESS

Chenoweth Long Chestnut

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D41993

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41993

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hosp.*)

ST. *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Mc Simon

(a) RESIDENCE, NO. *588 Russtman*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *11* yrs.

mos.

ds. How long in U. S., if of foreign birth? *11* yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Negro

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Beatrice Mc Simon

6 DATE OF BIRTH (month, day, and year) *12/24/1884*

7 AGE

Years *35*

Months *3*

Days *5*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

Regent

(c) Name of employer

McSchwab

9 BIRTHPLACE (city or town) (State or country)

D. America

10 NAME OF FATHER

Robert Mc Simon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

D. America

12 MAIDEN NAME OF MOTHER

Ellen Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

D. America

14

Informant (Address)

Eliza Mc Simon 588 W. Chestnut

15

APR 6 - 1920

ROBERT R. KAUTER Registrar

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/4* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

3/31 19*20* to *4/4* 19*20*

that I last saw him alive on *4/4* 19*20*

and that death occurred, on the date stated above, at *10 a. m.*

The CAUSE OF DEATH* was as follows:

Chronic Pericarditis + Chronic Intestinal nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *yes*

What test confirmed diagnosis?

(Signed) *Wm. D. Roddy* M. D.

48 19*20* (Address) *Mary 1st*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Cem

April 7th 19*20*

20 UNDERTAKER

Samuel F. Hensley

ADDRESS

578 W. Biddle

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41994

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 7

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH.

March 17, 1920

(Month)

(Day)

(Year)

7-AGE.

19 yrs., mos., ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Child

9-BIRTHPLACE.
(State or Country).

Bucko, Md.

10-NAME OF FATHER.

Isaac Evans

11-BIRTHPLACE OF FATHER
(State or Country).

Russia

12-MAIDEN NAME OF MOTHER

Sarah Foreman

13-BIRTHPLACE OF MOTHER
(State or Country).

Bucko, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam Foreman

(Address) 3022 Anchenbury Lane

15-

APR 6 - 1920

ROBERT H. REAUTE

Burial Place (Name)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

April 5, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 17, 1920, to April 5, 1920,

that I saw her alive on April 5, 1920,

and that death occurred, on the date stated above, at 5:00 p.m.

The CAUSE OF DEATH* was as follows:

Malaria Recrudescens

(Duration) 19 yrs., mos., ds.

CONTRIBUTORY
(Secondary)

(Duration) 4 yrs., mos., ds.

(Signed) Harry Goldmann, M.D.
4.5, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

D. C.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Hebrew Herring Run

4-6, 1920

20-UNDERTAKER

ADDRESS

Jack Lewis, 1411 E. Baco

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41995

D41995

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Fairfield 9th W.* ST.: *25* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary Robinson*(Residence in Baltimore: No. *Fairfield* St.: yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *Colored*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *Apr. 21, 1910*
(Month) (Day) (Year)

7-AGE, yrs. mos. da. If LESS than 1 day, hrs. or min.

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work,
- None*
-
- (b) General nature of industry, business, or establishment in which employed (or employer),
- None*

9-BIRTHPLACE, (State or Country), *Maryland*

PARENTS.

10-NAME OF FATHER, *William Robinson*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER, *Anna Vandergriff*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William Robinson*(Address) *Fairfield Md.*

15-

Filed

APR 6 - 1920

ROBERT F. BRADY

Burial in the

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Apr. 21, 1910*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Apr. 21, 1910*, to *Apr. 21, 1910*, that I saw him alive on *Apr. 21, 1910*, and that death occurred, on the date stated above, at *11⁰⁰ a. m.*

The CAUSE OF DEATH* was as follows:

Malnutrition(Duration) yrs. mos. da. *10 mos.*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) *William A. C. H.* M. D.*Apr. 21, 1910* (Address) *816 - Pennington St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Union Branch*DATE OF BURIAL, *4/6/20*20-UNDERTAKER *M. Robinson*ADDRESS *Fairfield*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41996

CERTIFICATE OF DEATH.

151 D41996
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Fairfield 9th 1/2* ST.; *25* WARD)

2-FULL NAME

(Residence in Baltimore: No. *Fairfield* St.; yrs. mos. ds)

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, *Single*, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

Apr. 5, 1910
(Month) (Day) (Year)

7-AGE,

yrs. mos. ds.

If LESS than 1 day,
hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*None**None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*William Robinson*11-BIRTHPLACE OF FATHER
(State or Country),*Maryland*

12-MAIDEN NAME OF MOTHER

*Anna Vanlandingham*13-BIRTHPLACE OF MOTHER
(State or Country),*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William Robinson*(Address) *Fairfield*

15-

Filed

APR 6 - 1920

ROBERT A. KRAUTH

Baltimore Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr. 5, 1910
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr. 5, 1910, to *Apr. 5, 1910*,that I saw her alive on *Apr. 5, 1910*,and that death occurred, on the date stated above, at *11:20* m.

The CAUSE OF DEATH* was as follows:

M. albutriton

.....

(Duration)..... yrs. mos. *1/2 hr.*CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *William D. Cox* M. D.*Apr. 5, 1910* (Address) *816 Pennington Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Funeral Branch

DATE OF BURIAL,

4/6/20, 1910

20-UNDERTAKER

Wm Robinson

ADDRESS

Fairfield

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41997

CERTIFICATE OF DEATH.

REGISTERED NO. C

D41997

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 N. Washington ST.; 7 WARD)

2-FULL NAME

(Residence in Baltimore: No. 527 N. Washington St.; 57 yrs., 5 mos., 5 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married
(Write the word.)

6-DATE OF BIRTH, Oct 28, 1862
(Month) (Day) (Year)

7-AGE, 57 yrs., 5 mos., 7 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), City

10-NAME OF FATHER, William Nicolaus

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Helen Kimmel

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Nicolaus

(Address) 527 N. Washington St.

15- APR 6 - 1920
Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 4, 1910
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1910, to April 4, 1910, that I saw him alive on April 4, 1910, and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Oak Lawn Cem April 7..., 1920

20-UNDERTAKER ADDRESS

W. J. Hartley 813 N. Washington

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Dks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D41998

CERTIFICATE OF DEATH

38

D41998

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. _____ ST.; _____ WARD)

2-FULL NAME

(Residence in Baltimore: No. _____ St.; _____ yrs., _____ mos., _____ ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-STATUS.
MARRIED
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER,
(State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER,
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

APR 6 - 1920

191

ROBERT A. LAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

3-4-20 191, to 4-4-20 191

that I saw her alive on April 4 191

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Bilateral
hypertension
(Duration) 10 yrs. 12 mos. 12 ds.

CONTRIBUTORY
(Secondary)

(Duration) 8 yrs. 12 mos. 12 ds.

(Signed) John C. Stewart M. D.

4-5-20 1920 (Address) 704 W. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41999

CERTIFICATE OF DEATH.

D41999

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *211 Jny ally*

ST.: *4*

WARD)

2-FULL NAME

Mary Epps

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

211 Jny ally

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2* yrs.

mos.

ds.

How long in U. S., if of foreign birth? *Apr* yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1813

7 AGE

Years

Months

Day

If LESS than 1 day, hrs. or min.

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

New Madison and Carroll Co.

10 NAME OF FATHER

John Epps

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Atlanta Ga

12 MAIDEN NAME OF MOTHER

Educ Quincy

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

New Madison and Carroll Co.

14

Informant (Address)

John Epps 211 Jny ally

15

APR 6 1920

ROBERT A. BLANTER

Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 4 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 24 1920 to *April 4 1920*

that I last saw her alive on *April 3 1920*

and that death occurred, on the date stated above, at *9:30 a.m.*

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. *12* ds.

CONTRIBUTORY (Secondary)

Probably influenza

(duration) yrs. mos. *5* ds.

18 Where was disease contracted

if not at place of death?

Place of death

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

L

(Signed)

H. K. Fennell

M. D.

45. 1920 (Address)

117 W. Saratoga St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Old burying place

April 6 1920

20 UNDERTAKER

ADDRESS

Daniel Taylor

60 W. ...

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42000

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

28

D42000

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1500 N. Caroline St

ST. 9 WARD)

2-FULL NAME William J. Tobin

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1500 N. Caroline St

St. 24 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH Aug. 12, 1894 (Month) (Day) (Year)

7-AGE 25 yrs. 7 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Plumber (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto. County

10 NAME OF FATHER Wm. M. Tobin

11 BIRTHPLACE OF FATHER (State or country) Balto. County

12 MAIDEN NAME OF MOTHER Sophia J. Jockad

13 BIRTHPLACE OF MOTHER (State or country) Balto. County

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. M. Tobin

(Address) Aberdeen Md.

15 APR 6 - 1920

ROBERT F. LEAUTEN

Bureau of Health

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Apr 4, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 25, 1920 to Apr 4, 1920 that I saw him alive on Apr 4, 1920 and that death occurred, on the date stated above, at 9 a.m. The CAUSE OF DEATH* was as follows:

Emic Endocarditis
Secondary Tuberculosis
(Duration) 3 yrs. mos. ds.

Contributory (SECONDARY) (Duration) 1 yr. mos. ds. (Signed) J. H. Thomas M. D. Apr 1920 (Address) 1228 N. Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted. If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL St. Charles Cemetery DATE OF BURIAL April 7, 1920

20-UNDERTAKER William G. Schaeffer ADDRESS 1816 Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

Cash Ellerbe

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital*)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

26 days

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 11 - 1871*

7 AGE Years *49* Months *10* Days *6* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Marion County* (State or country) *South Carolina*

10 NAME OF FATHER *William Ellerbe*

11 BIRTHPLACE OF FATHER (city or town) *South Carolina* (State or country)

12 MAIDEN NAME OF MOTHER *M. Baselder*

13 BIRTHPLACE OF MOTHER (city or town) *South Carolina* (State or country)

14 Informant *J. H. H. H. H.* (Address)

15 *APR 6 - 1920* *ROBERT H. KRAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 6 1920*

17 I HEREBY CERTIFY, That I attended deceased from *April 11*, 1920, to *April 6*, 1920, that I last saw him alive on *April 6*, 1920, and that death occurred, on the date stated above, at *1:15* a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

CONTRIBUTORY (Secondary)

(duration) *8* yrs. mos. ds. *Pulmonary tuberculosis*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Hospital signs.*

(Signed) *J. H. H. H. H.* M. D.

19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Gatta S. C. *4/6/20*

20 UNDERTAKER ADDRESS

J. Ahrens & Co. 121 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1009 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital*)

2-FULL NAME *Mr. Francis J. Overdorff*

(a) RESIDENCE. NO. *154 7 Street, Johnstown Pa.*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

unmarried

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

0.

6 DATE OF BIRTH (month, day, and year)

Nov. 5-1840

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

79

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pennsylvania

10 NAME OF FATHER

Jacob Overdorff

11 BIRTHPLACE OF FATHER (city or town) (State or country)

York Pa.

12 MAIDEN NAME OF MOTHER

0.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

York Pa.

14

Informant (Address)

John H. Records

15

Filed *APR 6 - 1920*

ROBERT A. LAUTER

Registrar

Barial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 6 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 12 1920 to April 5 1920

that I last saw him alive on *April 5 1920*

and that death occurred, on the date stated above, at *3:25 a.m.*

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

CONTRIBUTORY (Secondary)

(duration) *2* yrs. *2* mos. *0* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Yes*

(Signed) *John H. Records* M. D.

, 19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Johnstown Pa.

4/6/1920

20 UNDERTAKER

ADDRESS

J. Ahrens Co. 721 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST.: *6th* WARD)

2-FULL NAME *Annie Reserke*

(a) RESIDENCE, No. *2032 E. Fayette St Baltimore Md* ST.: *6th* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs. *Life* mos.

ds. How long in U. S., if of foreign birth?

Yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept 17 - 1919*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Edward Reserke

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Eva. Rausch

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

J. H. H.

15

APR 6 - 1920

ROBERT H. LAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 5 1920*

17

I HEREBY CERTIFY, That I attended deceased from *March 26 -* 1920, to *April 4* 1920.

that I last saw her alive on *April 4* 1920, and that death occurred, on the date stated above, at *9:30 p. m.*

The CAUSE OF DEATH* was as follows

Pyelonephritis

(duration) yrs. mos. ds. *14 + ds.*

CONTRIBUTORY (Secondary) *none*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Patent home*

Did an operation precede death? *No* Date of *20*

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Autopsy*

(Signed) *Car. H. H.* M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer Cemetery

20 UNDERTAKER

Lilly & Ziehl

DATE OF BURIAL

April 6th 1920

ADDRESS

4038 Maple St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42004

CERTIFICATE OF DEATH.

92 D42004

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 S. Chapel ST.; 2 WARD)

2-FULL NAME

(Residence in Baltimore: No. 217 S. Chapel St.;yrs., 2 mos.,ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

.....Jan 20....., 1920
(Month) (Day) (Year)

7-AGE,

.....2 yrs., 16 mos.,ds.

If LESS than 1 day,

.....hrs. or.....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....Child

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),Balto. Md.

10-NAME OF FATHER,

William F. Maurer11-BIRTHPLACE OF FATHER
(State or Country),Balto. Md.

12-MAIDEN NAME OF MOTHER

Annie Mauley13-BIRTHPLACE OF MOTHER
(State or Country),Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....William F. Maurer.....(Address).....217 S. Chapel St......

15-

Filed

APR 26 - 1920

19

ROBERT B. RAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

.....April 5....., 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 4 1920, to April 5 1920,that I saw her alive on April 5 1920,and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....E. J. Hall.....M. D......, 1920 (Address).....937 Myrtle.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn Cemetery

DATE OF BURIAL,

April 7....., 1920

20-UNDERTAKER

Lilly & Zeiler

ADDRESS

4038 W. 4th

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42005

CERTIFICATE OF DEATH.

D42005

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.;

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1933* St.; *25* yrs., *1* mos. *22* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH,

March 13 *in* *1895*
(Month) (Day) (Year)

7-AGE,

25 yrs. *1* mos. *22* ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Shoemaker at home

9-BIRTHPLACE,

(State or Country),

Balto. Md.

10-NAME OF FATHER,

John Zajac

11-BIRTHPLACE OF FATHER

(State or Country),

Balto. Md.

12-MAIDEN NAME OF MOTHER

Catherine Marchalik

13-BIRTHPLACE OF MOTHER

(State or Country),

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Julia Zajac*

(Address) *1933 Albemarle St.*

15-

APR 6 - 1920

191

ROBERT H. ERAUTER

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 4, *1920*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 29 1920, to *April 4 1920*,

that I saw him alive on *April 4 1920*,

and that death occurred, on the date stated above, at *5:20 a.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *J. B. Brown* M. D.

4-4, *1920* (Address) *St. Joseph's Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted,

if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Holy Redeemer

DATE OF BURIAL,

April 7, 1920

20-UNDERTAKER

Lilly & Zuber

ADDRESS

4033 Wagon St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42006

CERTIFICATE OF DEATH.

91 D42006

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. *St Agnes Hospital* ST. *15* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Ella Ernsthagen*(a) RESIDENCE. NO. *2819 Woodmont Ave* ST. *15* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1 1/2* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX *F* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced (write the word) *married*16 DATE OF DEATH (month, day, and year) *Apr 6* 19 *20*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *John Ernsthagen*

17 I HEREBY CERTIFY, That I attended deceased from

Mar 27, 19 *20*, to *Apr 6*, 19 *20*,that I last saw her alive on *Apr 6*, 19 *20*,and that death occurred, on the date stated above, at *2 4* m.

The CAUSE OF DEATH* was as follows;

*Pneumonia*6 DATE OF BIRTH (month, day, and year) *Sept 18 71*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *48*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

CONTRIBUTORY (Secondary)

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Dr. J. P. Parker* M. D., 19 (Address) *St Agnes Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER *John P. Whaley*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *Caroline*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Utah*14 Informant *John Ernsthagen* (Address) *Same as -*15 *APR 6 - 1920* *ROBERT E. ELLIOTT* Registrar

Burial Permit Office

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Cathedral *Apr 8* 19 *20*
John F. Foley, Son of 27 W. 1st St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42007

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42007

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Calhoun & Lombard Sts. St.:

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabelle E. Purper

(Residence in Baltimore: No. 640 W. Lombard St.

Life St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Feb. 10, 1884.
(Month) (Day) (Year)

7-AGE,

36 yrs. 1 mos. 24 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Candy Packer

9-BIRTHPLACE,

(State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER,

George Wiseman

11-BIRTHPLACE OF FATHER

Md.

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mildred Bertholt

(Address) 709 W. Fayette St.

15-

APR 6 - 1920 ROBERT H. EBAUTER

Filed 191 Bureau of Health

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr. 3, 1920, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held Inquest & Autopsy.
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest.
(Inquest, au-

Autopsy find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet shot wounds through the
body and heart. Stab through the
Liver. Homicide.

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Smith M. D.

4/5/20 (Coroner)

191 (Address) 1001 R St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Cem

Apr. 6, 1920

20-UNDERTAKER

ADDRESS

Joseph B. Cook

1003 M. St.

D42008

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42008

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Luigi DUNDAS BARTOLECCI*(a) RESIDENCE. No. *1744 N. S.*, ST. *Washington, D. C.*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *7* ds. How long in U. S., if of foreign birth? yrs. *7* mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Single</i>
----------------------	---------------------------------	---

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *June 17-1888*

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<i>32</i>	<i>9</i>	<i>14</i>		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Naval attaché with*(b) General nature of industry, business, or establishment in which employed (or employer) *Italian Naval Embassy*

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) *Italy*10 NAME OF FATHER *Thomas Bartolucci*11 BIRTHPLACE OF FATHER (city or town)
(State or country) *Italy*12 MAIDEN NAME OF MOTHER *Clotilde Juge*13 BIRTHPLACE OF MOTHER (city or town)
(State or country) *Italy*14 Informant *Hospital Records*
(Address)15 Filed *APR 6-1920* ROBERT R. KAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 1st 1920*

17 I HEREBY CERTIFY, That I attended deceased from
March 25th 1920, to *April 1st 1920*,
that I last saw him alive on *April 1st 1920*,
and that death occurred, on the date stated above, at *4:40* m.

The CAUSE OF DEATH* was as follows:

*Cerebral Meningitis following
mastoid operation*

CONTRIBUTORY *Chronic Mastoiditis*
(Secondary) (duration) yrs. mos. *4* ds.
(duration) yrs. *2* mos. ds.

18 Where was disease contracted
If not at place of death?Did an operation precede death? *yes* Date of *March 26-1920*
*March 30 1920*Was there an autopsy? *No*

What test confirmed diagnosis? *Decompression done 3/30/20*
Shaved meningitis
(Signed) *William S. Tillet*, M. D.

4/1/20 1920 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Washington, D. C.**5/1/ 1920*

20 UNDERTAKER

ADDRESS

*Henry W. Meas & Son**805 1/2 Calvert*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42009

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42009

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 312 S. Vincent

St. 19

WARD)

2-FULL NAME Annie Johnson

(Residence in Baltimore: No. 312 S. Vincent St.

REGISTERED NO. C

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

St. 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

female

4-COLOR OR RACE,

colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH,

Dec.

19,

1877 1920

(Month)

(Day)

(Year)

7-AGE,

43

yrs.

3

mos.

16

ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Dom.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Md.

10-NAME OF FATHER,

Jno. Simms

11-BIRTHPLACE OF FATHER

(State or Country), Md.

12-MAIDEN NAME OF MOTHER

Johanna Smith

13-BIRTHPLACE OF MOTHER

(State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Slocum

(Address) 306 N. Eden St.

15-APR 6 - 1920

ROBERT A. ELLIOTTER

Filed 191 Serial Permit City Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 4, 1920 191

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, au

inquiry and that said deceased came to her death (Inquest, au topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. E. Smith (Duration) yrs. mos. ds.

(Coroner) M. D.

191 (Address) 910 E. Light St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Auburn Cem April 7, 1920

20-UNDERTAKER

ADDRESS

a. Jones 20 S. Strickland

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

D42010

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42010

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Thame ST.; 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agatha Sysko

(Residence in Baltimore: No. 1614 Thame St.; 20 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH,

September 10, 1883
(Month) (Day) (Year)

7-AGE,

64 yrs., 6 mos., 24 ds.

If LESS than 1 day, 0 hrs. or 0 min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House work

9-BIRTHPLACE, (State or Country),

Russia Poland

10-NAME OF FATHER,

Shenk

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Sadowski

(Address) 705 S. Ann St

15-

Robert P. Harrison,

Filed APR 10 1920 Registrar.

Burial Permit CL

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 4, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 30, 1920, to April 2, 1920,

that I saw her alive on April 2, 1920,

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) 2 yrs., 0 mos., 0 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 6 yrs., 0 mos., 0 ds.

(Signed) J. J. Sadowski M. D.

April 5, 1920 (Address) 722 S. Ann St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

Apr 7, 1920

20-UNDERTAKER

M. F. Sadowski

ADDRESS

705 S. Ann

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PH. S. C. L. A. S. should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42011

CERTIFICATE OF DEATH.

D42011

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.: *1-2* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mr. John B. Thomas*

(a) RESIDENCE. No. *14 W. 25th*

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *25* yrs. mos. ds. How long in U. S., if of foreign birth? *life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

male

white

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Anna Stuart Thomas

6 DATE OF BIRTH (month, day, and year) *1857*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

63

10

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Accountant*

(b) General nature of industry, business, or establishment in which employed (or employer)

New Amsterdam Co. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) *Queen Anne's Co. Md.*
(State or country)

10 NAME OF FATHER *Unknown*

11 BIRTHPLACE OF FATHER (city or town) *md*
(State or country)

12 MAIDEN NAME OF MOTHER *Hopper*

13 BIRTHPLACE OF MOTHER (city or town) *md*
(State or country)

14 Informant *Anna Stuart Thomas*
(Address)

15 *Robert P. Harrison*
Registrar

APR 6 - 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 6* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

3/31, 19 *20*, to *April 6*, 19 *20*.

that I last saw him alive on *April 6*, 19 *20*.

and that death occurred, on the date stated above, at *4:55 a. m.*

The CAUSE OF DEATH* was as follows:

Emphysema of left chest

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *yes* Date of *3/31/20*

Was there an autopsy? *no*

What test confirmed diagnosis? *operation*

(Signed)

John B. Harrison M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery *April 8* 19 *20*

20 UNDERTAKER

John Mitchell

ADDRESS *1201 W. Fayette*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-10 H. P. Co. 1000 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42012

CERTIFICATE OF DEATH.

D42012

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square Hospital* ST. *16* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Miss Elva Johnson*

(a) RESIDENCE. NO. *1804 Edmondson Ave.* ST. WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *14* yrs. *3* mos. *9* ds. How long in U. S., if of foreign birth *Life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec. 27, 1905*

7 AGE *14* Years *3* Months *9* Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *School girl*

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md.* (State or country)

10 NAME OF FATHER *Clarence Johnson*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Anne Arundel Co Md.*

12 MAIDEN NAME OF MOTHER *Mary Crane*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Anne Arundel Co*

14 Informant *Clarence S. Johnson* (Address) *1617 W. Laverne St.*

15 Filed *Robert E. Harrison* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 5* 19 *20*

17 I HEREBY CERTIFY, That I attended deceased from *March 7,* 1920, to *Apr. 5*, 1920,

that I last saw him alive on *April, 5*, 1920,

and that death occurred, on the date stated above, at *3.27 P. M.*

The CAUSE OF DEATH* was as follows:

acute articular Rheumatism
(Jan. 1919)

(duration) yrs. *3* mos. ds.

CONTRIBUTORY *Endocarditis* (Secondary)

(duration) yrs. *1* mos. ds.

18 Where was disease contracted if not at place of death? *Home*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Lyman S. Abbott* M. D.

, 19 (Address) *Franklin Sq. Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Druid Ridge

April 7 1920

20 UNDERTAKER

John O. Mitchell

ADDRESS

1214 Fayette St.

Burial Permit Clerk

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D42013

HEALTH DEPARTMENT—CITY OF BALTIMORE

(Nehmaman)

D42013

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *118 S Wolfe* ST.; *2* WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. *118 S Wolfe* ST. *33* yrs., *3* mos., *1* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*

4-COLOR OR RACE *White*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*

6-DATE OF BIRTH *Nov 2, 1847*

(Month)

(Day)

(Year)

7-AGE, *73* yrs., *3* mos., *1* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Cigar Maker*
(b) General nature of industry, business, or establishment in which employed (or employer) *By*

9-BIRTHPLACE, (State or Country) *Germany*

10-NAME OF FATHER *John Nehmaman*

11-BIRTHPLACE OF FATHER (State or Country) *Germany*

12-M maiden NAME OF MOTHER *St. Department*

13-BIRTHPLACE OF MOTHER (State or Country) *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert P. Harrison*

(Address) *2130 Baltimore*

15-

Robert P. Harrison,

Filed *1920*

Burial Permit *191*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *4 - 3, 1920*

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from *3 - 3 - 1920*, to *4 - 3 - 1920*,

that I saw him alive on *4 - 3 - 1920*

and that death occurred, on the date stated above, at *8-55* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung and Cervix Uteri
(Duration) *One* yrs., *11* mos., *11* ds.

CONTRIBUTORY (Secondary) *Carcinoma of Lung*

(Signed) *Richard M. D.*

4-6-20 Address *500 S. ...*

*State the DISEASE CAUSING DEATH or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *4* yrs., *3* mos., *1* ds. In the State *4* yrs., *3* mos., *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer Am.*

DATE OF BURIAL, *April 7, 1920*

20-UNDERTAKER *Lilly and Ziehl*

ADDRESS *403 S. Wolfe*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D42014

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42014

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mount Hope Retreat* ST.; *15th* WARD)

2-FULL NAME

(Residence in Baltimore: No. *3018 O'Donnell St.* St.; *50* yrs., *0* mos., *0* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*

6-DATE OF BIRTH,

Don't know

(Month)

(Day)

(Year)

7-AGE,

abt

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country)

Germany

PARENTS.

10-NAME OF FATHER,

Don't know

11-BIRTHPLACE OF FATHER

(State or Country),

Germany (?)

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany (?)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Records of Mt Hope Retreat

(Address)

Mt Hope Balto Md

15-

Robert P. Harrison,

Filed

1920

191

191

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 5

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mich 14th 1920

to

April 5 1920

that I saw him alive on

Apr 4

191

and that death occurred, on the date stated above, at

3. a.

m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism and

Paralysis

abt

(Duration)

0

yrs.

1

mos.

0

ds.

CONTRIBUTORY

(Secondary)

abst

(Duration)

0

yrs.

1

mos.

0

ds.

(Signed)

F. J. Harrison

M. D.

....., 191... (Address) *Mt Hope Md*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

of death

yrs.

mos.

17

ds.

State

yrs.

mos.

17

ds.

Where was disease contracted, if not at place of death?

Baltimore Md

Former or

usual residence

Baltimore Md

19-PLACE OF BURIAL OR REMOVAL,

New Catholic

DATE OF BURIAL

April 8, 1920

20-UNDERTAKER

Lily and Zeller

ADDRESS

403 S. W. 10th

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42015

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1417 Cook St.* ST. *2nd* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1417 Cook St.* St. *2nd* yrs. *9* mos. *10* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)
Married

6-DATE OF BIRTH

1878
(Month) (Day) (Year)

7-AGE

47 yrs. *—* mos. *—* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. J. Harrison*(Address) *1417 Cook St.*

15-

APR 6 - 1920

Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

4 - 4 - 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *2 - 1 - 1920*, to *4 - 4 - 1920*, that I saw him alive on *4 - 4 - 1920*, and that death occurred, on the date stated above, at *8 P. M.*

The CAUSE OF DEATH* was as follows:

Tuberculosis of Larynx
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)*Influenza*
(Duration) yrs. mos. ds.(Signed) *St. Piroch* M. D.*4 - 5 - 1920* (Address) *2202 North*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

D42016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42016

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *St. Joseph's Hospital* ST.; *6* WARD)2-FULL NAME *William H. Gill*(Residence in Baltimore: No. *2309 E. Fairmount Ave.* St. *Refers*, mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Widowed*
(Write the word.)

6-DATE OF BIRTH, *June 1st 1865*
(Month) (Day) (Year)

7-AGE, *54* If LESS than 1 day, yrs. mos. ds. *9 mos. 25 ds.* ...hrs. or...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Labor*
(b) General nature of industry, business, or establishment in which employed (or employer). *City.*

9-BIRTHPLACE, (State or Country), *Baltimore, Md.*

10-NAME OF FATHER, *Elijah H. Gill*

11-BIRTHPLACE OF FATHER (State or Country), *D.C.*

12-MAIDEN NAME OF MOTHER *Melindia J. Cannon*

13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William H. Gill*
(Address) *114 Belmar Ave.*

15- *Robert P. Harrison*
APR 6 - 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 5, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *March 29 1920*, to *April 5 1920*, that I saw him *die* on *April 5 1920*, and that death occurred, on the date stated above, at *9:30 a.m.*

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. ds. *1 ds.*
CONTRIBUTORY (Secondary) *Polar Pneumonia*

(Duration) yrs. mos. ds. *3 ds.*
(Signed) *J. B. Brannan* M. D.

4-5, 1920. (Address) *St. Joseph's Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Oak Lawn Cemetery *Apr. 8, 1920*

20-UNDERTAKER ADDRESS

John A. Moran *3000 E. Balto.*

RESERVED FOR
UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOTICE

The succeeding documents
were received in the same
condition and microfilmed
as shown.

Every effort was made to
assure legibility and com-
pleteness.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42017

CERTIFICATE OF DEATH

120-1042017

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No.)

2 FULL NAME

(Residence in Baltimore: No.)

ST. 16 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Sr. 0 yrs. 0 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (If write the word) Married

6 DATE OF BIRTH January 31, 1869 (Month) (Day) (Year)

7 AGE 53 yrs. 2 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Merchant (Self)

9 BIRTHPLACE (State or country) St. Mary Co. Md

10 NAME OF FATHER Robert B. Tippet

11 BIRTHPLACE OF FATHER (State or country) St. Mary Co. Md

12 MAIDEN NAME OF MOTHER Susan E. Payne

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. R. B. Tippet (brother)

(Address) Fidelity Building

15 Robert

APR 6 - 1920

191 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 5, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased fr March 22, 1920, to April 5, 1920 that I saw him alive on April 5, 1920 and that death occurred, on the date stated above, at The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 10 yrs. mos. d Contributory Nephritis (acute) (SECONDARY)

(Signed) Herbert E. Tippet April 6, 1920 (Address) 300 N. Holliday St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 10 ds. State 53 yrs. 2 mos. 5 ds.

Where was disease contracted, If not at place of death? Former or usual residence Millstone St. Mary Co. Maryland

19 PLACE OF BURIAL OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL April 7, 1920 ADDRESS 108

STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

MARGIN RESERVED FOR BIRTHING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-17—H. P. Co.—1000 I. S.

D42018

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42018

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 Madison Ave ST.: 11 WARD)

2-FULL NAME

Emily Cassard Tyler

(a) RESIDENCE. No. 1116 Madison Ave ST.: 11 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. 9 mos. 30 ds.

How long in U. S., if of foreign birth? 84 yrs. 9 mos. 30 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Resident

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of General E. B. Tyler

6 DATE OF BIRTH (month, day, and year) June-6-1835

7 AGE Years 84 Months 9 Days 30 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Gilbert Cassard

11 BIRTHPLACE OF FATHER (city or town) France (State or country)

12 MAIDEN NAME OF MOTHER Sarah Wilcox

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

PARENTS

14 Informant Mrs. Mary J. Reese - (niece)

(Address) 1116 Madison Ave

Robert F. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5-1920

17 I HEREBY CERTIFY, That I attended deceased from 11:16 a.m., 1920, to April 5, 1920.

(that I last saw her alive on Apr. 4, 1920, at 8 a.m.)

and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Industrial Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. C. Clarke, M.D.

4.5.1920 (Address) 2400 E. Ave.

*State the Disease Causing Death, or in death from Violent Cause state (1) Means and Nature of Injury, and (2) whether Accident, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Green Mount Cemetery

April 5, 1920

20 UNDERTAKER

STEWART & MOWEN COMPANY

108 W. N. C.

(WILLIAM F. WOODEN, Successor)

APR 6 - 1920

Burial Permit Clerk

D42019

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42019

CERTIFICATE OF DEATH.

I-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1638 Hollbrook*ST.: *9* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Horace W Zimmerman*(a) RESIDENCE. No. *1638 H R Brook*

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 20 1919*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *7 17*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*10 NAME OF FATHER *Raymond W Zimmerman*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Bessie J. Maltz*13 BIRTHPLACE OF MOTHER (city or town) *Fredricks* (State or country) *Maryland*14 Informant *Raymond W Zimmerman* (Address) *1638 Hollbrook St*15 Filled *Robert P. Harrison,* Registrar

APR 6 - 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 6* 19*20*17 I HEREBY CERTIFY, That I attended deceased from *April 2nd* 19*20*, to *April 6th* 19*20*, that I last saw him alive on *April 6* 19*20*, and that death occurred, on the date stated above, at *1 P* m.

The CAUSE OF DEATH* was as follows:

*Measles*CONTRIBUTORY *Broncho Pneumonia* (Secondary) (duration) yrs. mos. *4* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *M. A. Fair*, M. D.April 6, 1920 (Address) *12 E 25th*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St Olwet**April 8* 1920

20 UNDERTAKER

ADDRESS

*John F Denny**715 Light*

D42020

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42020

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert F. Harrison,

APR 6 - 1920

191

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

Apr. 1 " 1919, to Apr. 6 " 1920.

that I saw him alive on Apr. 3 1920.

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificate.

D42021

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42021

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Horace E. Crittenton Mission* ST.; *18* WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Little Horace Wagner*(Residence in Baltimore: No. _____ St.; _____ yrs., *1* mos. *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *F* 4-COLOR OR RACE, *W* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH, *March 3, 1920*
(Month) (Day) (Year)

7-AGE, *1* yrs. *3* mos. *3* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... *Infant*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER, *Not Known*

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER *Lillian Wagner*

13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... *Robert P. Harrison*

(Address)..... *837 Hollins St.*

15-

Robert P. Harrison,

APR 6 - 1920

191

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 6, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Mar 14* 191*8*, to *Apr 6* 191*8*, that I saw h*er* alive on *April 5* 191*8*, and that death occurred, on the date stated above, at *6* A. m.

The CAUSE OF DEATH* was as follows:

Immaturity
(Duration)..... yrs. *1* mos. *3* ds.

CONTRIBUTORY... *Congenital Atelectasis*
(Secondary)

(Signed)..... *John J. Alderson*, M. D.
Apr 6, 1920 (Address)..... *501 1307 Bldg.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Lorraine Cent

DATE OF BURIAL,

4/6, 1920

20-UNDERTAKER

Wm. Cook

ADDRESS

1825 N. 1st St.

CAUSE OF DEATH in plain terms, so that it may be properly claimed. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42022

CERTIFICATE OF DEATH.

109 D42022

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST.: 17

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roberta Brown(a) RESIDENCE. No. Unknown 581 Oxford

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

FemaleBlackMarried

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 1865

7 AGE

Years

Months

Days

If LESS than
1 day,.....hrs.
or.....min.55

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown9 BIRTHPLACE (city or town) Virginia
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14

Informant Hospital Records

(Address)

New City Hospital.

15

FRI APR 7 - 1920ROBERT R. KRAUTER

Registrar

Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 19 20

17

I HEREBY CERTIFY, That I attended deceased from
November 23, 19 17, to April 3, 19 20.that I last saw her alive on April 3, 19 20.and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcerunknown (duration) yrs. mos. ds.CONTRIBUTORY Intestinal Obstruction
(Secondary)unknown (duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?UnknownDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? no special test(Signed) J. P. Pessel, M. D.19 PLACE OF BURIAL, CREMATION OR REMOVAL Address New City Hospital.

DATE OF BURIAL

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Int. Auburn CemeteryApr 7 19 20

20 UNDERTAKER

Geo. H. Holland

ADDRESS

1631 Spring Hill Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42023

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1408 N. Chest

ST.

WARD) 8

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Florence Wright

(Residence in Baltimore: No.

1408 N. Chest

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

Apr. 6, 1920
(Month) (Day) (Year)

7-AGE,

yrs. mos. ds.

IF LESS than 1 day,
hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Md.

10-NAME OF FATHER,

Joseph N. Wright

11-BIRTHPLACE OF FATHER,
(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Sarah H. Murrell

13-BIRTHPLACE OF MOTHER,
(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. Wright

(Address)

1408 N. Chester

15- APR 7 - 1920

ROBERT B. KAUTER

Filed

191

Burial

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr. 6, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 6 1920, to Apr 6 1920, that I saw her alive on Apr 6 1920, and that death occurred, on the date stated above, at 4 P m. The CAUSE OF DEATH* was as follows:

Premature birth 7 months.
(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Signed) J. Wright M. D.
Apr 6, 1920 (Address) 1823 N. West

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore County

DATE OF BURIAL,

April 7, 1920

20-UNDERTAKER

George J. Ruth 7357 Hayford Ave.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42024

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

10-091 D42024

1 PLACE OF DEATH
CITY OF BALTIMORE (No. *1123 Briscar*)
2 FULL NAME *Mr. Book*
(Residence in Baltimore: No. *1123 Briscar*)
ST. *21* WARD
REGISTERED No. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
Su. *Life* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Cold* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write the word)

6 DATE OF BIRTH *June 2, 1894*
(Month) (Day) (Year)

7 AGE *24* yrs. *3* mos. *3* ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work *Train Engineer*
(b) General nature of industry, business, or establishment in which employed (or employer) *086*

9 BIRTHPLACE (State or country) *MD*

10 NAME OF FATHER *Chas. Cook*

11 BIRTHPLACE OF FATHER (State or country) *MD*

12 MAIDEN NAME OF MOTHER *Laura Brink*

13 BIRTHPLACE OF MOTHER (State or country) *in Caroline*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mr. George Hooper*

(Address) *406 4th Avenue*

15

APR 7 - 1920 ROBERT R. KRAUTER

REGISTRY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *4* *5*, 19*20*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *March 29, 1920* to *April 4, 1920*, that I saw him alive on *April 4, 1920*, and that death occurred, on the date stated above, at *m.*
The CAUSE OF DEATH* was as follows:

Influenza
Broncho Pneumonia

(Duration) yrs. mos. ds.

Contributory *Broncho Pneumonia*
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *Wm. B. Hall* M. D.

4.5, 19*20* (Address) *Halesbury*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Int. at St. Mary's *4/7*, 19*20*

20 UNDERTAKER ADDRESS

Mr. George Hooper *406 4th Avenue*

D42025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42025

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3107 Presbury ST.: 15 WARD)2-FULL NAME Annie Irene Newshaw(a) RESIDENCE. No. 3107 Presbury ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Asa L. Newshaw6 DATE OF BIRTH (month, day, and year) Sept 27-18677 AGE Years 52 Months 6 Days 9 If LESS than 1 day... hrs. or... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md10 NAME OF FATHER Harrison L. White11 BIRTHPLACE OF FATHER (city or town) (State or country) Md12 MAIDEN NAME OF MOTHER Ellen H. Butler13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md14 Informant A. J. Aldridge, D.D.S. (Address) 3107 Presbury St.15 APR 7-1920

ROBERT E. KAUSTER Registrar

Burial Permit Class

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 5 192017 I HEREBY CERTIFY, That I attended deceased from July 1919, to April 1920, that I last saw her alive on April 5th 1920.and that death occurred, on the date stated above, at 9:15 p.m.

The CAUSE OF DEATH* was as follows:

Secondary Staphylococcus
Septic pneumonia(duration) yrs. 4 mos. ds.CONTRIBUTORY Thrombosis of Lumbar Cord + Paralysis (Secondary)(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical signs(Signed) Isidore L. Doherty, M.D.27, 1920 (Address) 3014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Loudon Park Apr 8 1920

20 UNDERTAKER ADDRESS

W. F. Glickner & Son W & Pa

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42026

CERTIFICATE OF DEATH.

D42026

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 Barclay ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 538 Stevens St. Camden, N.J.

WARD.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred Since Jan. 17th 1920 How long in U. S., if of foreign birth? Born in N. J. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Thomas F. Lloyd

6 DATE OF BIRTH (month, day, and year)

June 6 1869

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

51

3

no

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

at home
None

(c) Name of employer

None

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)10 NAME OF FATHER Joseph A. Barnes11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)14 Informant John G. Medinger
(Address) 2104 Barclay St.15 APR 7 - 1920ROBERT A. LEADLEY
Registrar

Burial Permit No.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6th 1920

17

I HEREBY CERTIFY, That I attended deceased from

Jan 19th 1920, to April 6th 1920,that I last saw her alive on April 6th 1920,and that death occurred, on the date stated above, at 3⁰³ A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus(duration) yrs. 4 mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? ✓ Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? ✓(Signed) Adam a. Todd, M. D., 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Cem

DATE OF BURIAL

Apr 8 1920

20 UNDERTAKER

W. F. Tucker & Sons

ADDRESS

W. F. Tucker

Information should be carefully checked in plain terms, so that it may be properly entered. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D42027

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D42027

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *164 Colvin*)

ST. *5* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME *Fleet Jenkins*

(Residence in Baltimore: No. *164 Colvin*)

St. *40* yrs. *1* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *married*

6-DATE OF BIRTH *1842* (Month) *1* (Day) *1* (Year)

7-AGE *78* yrs. *1* mos. *1* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *Laborer* (b) General nature of industry, business, or establishment in which employed (or employer) *Laborer*

9-BIRTHPLACE (State or country) *Unknown* *lived in Baltimore 40 years*

10-NAME OF FATHER *Unknown*

11-BIRTHPLACE OF FATHER (State or country) *Unknown*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or country) *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mary J Jenkins*

(Address) *164 Colvin St.*

15

APR 7 - 1920

ROBERT E. KRAUTER

BURIAL PERMIT REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *April 4, 1920* (Month) (Day) (Year)

17- I HEREBY CERTIFY That I attended deceased from *November 28, 1917* to *April 3, 1920* that I saw him alive on *April 3, 1920* and that death occurred on the date stated above at *12:30 P. M.* The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) *2* yrs. *1* mos. *1* ds.

Contributory *Heart Failure* (SECONDARY)

(Duration) *1* yrs. *1* mos. *1* ds.

(Signed) *Frederick G. Hooper* M. D. *April 6, 1920* (Address) *112 S. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *1* yrs. *1* mos. *1* ds. In the State *1* yrs. *1* mos. *1* ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Mary Cemetery

DATE OF BURIAL

April 8, 1920

20-UNDERTAKER

Mrs. R. A. Elliot

ADDRESS

1725 Highland Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D39894
D42028

REGISTERED NO.

D42028

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Charles Hopkins Hospital* ST.: *5th* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Belara Jones

(a) RESIDENCE. NO.

29 N. Eden St. Baltimore, Md.

WARD.

North Carolina

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

married

6 DATE OF BIRTH (month, day, and year)

June 18 1897

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*22**9**15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

North Carolina
Baltimore 10 month

10 NAME OF FATHER

Wm. Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

North Carolina

12 MAIDEN NAME OF MOTHER

Lula Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

North Carolina

14

Informant (Address)

2111 Reems

15

Filed

*APR 7 - 1920**ROBERT B. KAUTER*

Registrar

BRIAL FARM CLARK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 5 1920

17

I HEREBY CERTIFY, That I attended deceased from

*week. 29 1920 to April 5 1920.*that I last saw her alive on *April 5 1920.*and that death occurred, on the date stated above, at *740 P. m.*

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia.

CONTRIBUTORY (Secondary)

Pulmonary Edema.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes.* Date of *March 30th 1920.*Was there an autopsy? *Yes.*

What test confirmed diagnosis?

(Signed) *John W. Harris, M. D.*(Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laural Cemetery

DATE OF BURIAL

April 8 1920

20 UNDERTAKER

Wm. R. A. Elliott

ADDRESS

1725 Ashland Ave.

Information should be carefully supplied. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 W. Mulberry St. ST. 17 WARD)

2-FULL NAME

Emma Smith

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

718 W. Mulberry St. ST. 17 WARD.

(Usual place of abode) Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 58 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

W.D. in Baltimore Life time

10 NAME OF FATHER

Amel Savage

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

by Kate Thomas 718 W. Mulberry St.

15

Date

APR 7 - 1920

ROBERT E. KRAUTER

ROBERT E. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1920, to April 4, 1920, that I last saw her alive on April 3, 1920, and that death occurred, on the date stated above, at 4 a.m. The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

since Feb 23, 1920 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? N Date of L

Was there an autopsy? N

What test confirmed diagnosis?

(Signed) W. G. Fouch, M. D.

46, 1920 (Address) 117 W. Sarabje

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Wm. Hurlburt Cemetery

APR 9 1920

20 UNDERTAKER

ADDRESS

Mrs. Robert A. Elliot

Ashland

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42030

CERTIFICATE OF DEATH.

91 D42030

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

407 S. Bond.

ST.; 3 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edward. Kompanowski

(a) RESIDENCE. No.

407 S. Bond

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single.

6 DATE OF BIRTH (month, day, and year)

March. 3-1918

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

1

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None.

(b) General nature of industry, business, or establishment in which employed (or employer)

"

(c) Name of employer

"

9 BIRTHPLACE (city or town) (State or country)

Pol.

10 NAME OF FATHER

Joseph. Kompanowski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland.

12 MAIDEN NAME OF MOTHER

Helena Przybylska

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland.

14

Informant (Address)

Joseph. Kompanowski
407 S. Bond.

15

Filed

19

ROBERT A. LAUTER

Registrar

APR 7 - 1920

Burial Permit 0121

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 6 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr 6 1920, to Apr 6 1920,

that I last saw him alive on Apr 6 1920,

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

407 S. Bond St.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Clinical exam.

(Signed) Nathan J. Helffoss, M. D.

19 (Address)

117 S. Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary

April 7 1920

20 UNDERTAKER

ADDRESS

117 S. Bond St. 1618 Eastern Ave.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

ORE
66 ✓

1112031

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

CORONER'S CERTIFICATE OF DEATH.

3-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

April 1, 1850
(Month) (Day) (Year)

70 yrs. mos. ds

...hrs. or...min.?

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Not Known

of known

Wf Keweenaw

Not Known

Not Known

(Informant).....

(Address).....

ROBERT A. LEAUTER

FIVE

APR 7 - 1920

101... Registrar.

TH, March, 1970
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the
remains described above, held an Autopsy
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, au-
..... find that said deceased came to death
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY.....
(Secondary)
..... (Duration)..... yrs..... mos..... da

(Duration) . . . yrs. . . mos. . . da.
 (Signed) Henry Louis Buckley M. D.
 (Coroner.)
 you 6 1914 (Address) 1010 E. 13th St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

IN-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place _____ In the _____
of depth _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

10-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
<i>Chapel Hill</i>	<i>April 7, 1902</i>

20-UNDERTAKER

Wm Rouleau

DATE OF BURIAL.

April 7, 1928

ADDRESS

230 Mr. Greene

D42032

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42032

1-PLACE OF DEATH

CITY OF BALTIMORE:

No. 720 N. Broadway

ST.:

WARD)

2-FULL NAME

Mary E. Gaunt

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

720 N. Broadway

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Feb. 9, 1859

7 AGE

61

Years

Months

25

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

Public School Teacher

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Samuel Gaunt

11 BIRTHPLACE OF FATHER (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Elizabeth Forsythe

13 BIRTHPLACE OF MOTHER (State or country)

Baltimore

14

Informant (Address)

Harry G. Harriman, Alexander, Va.

15

Filed

APR 7 - 1920

ROBERT B. BRAUTER

Registrar

Serial Permit 1101

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 5, 1920

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 29, 1920, to April 5, 1920,

that I last saw him alive on April 4, 1920,

and that death occurred, on the date stated above, at 11:30 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

R. Hemiplegia, Crura

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. B. Fiegler, M. D.

4-6-1920 (Address) 930 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore

April 5, 1920

20 UNDERTAKER

Girkler & Girkler

ADDRESS

1739 Eager

Information should be carefully supplied in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

D42033

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D42033

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

15

APR 7 - 1920

ROBERT E. EASTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1920

17

I HEREBY CERTIFY, That I attended deceased from

1/18, 1920, to 4/4, 1920,

that I last saw her alive on 4/4, 1920,

and that death occurred, on the date stated above, at 10:10 P. M.

The CAUSE OF DEATH* was as follows:

Phthisis
As. Pleuritis
(As Pleurisy followed by Phthisis)

(duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. M. R. Butler, M. D.

, 19 (Address) 2134 Duane St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Mt. Auburn Cemetery
John H. ToadwinApr. 7, 1920
1234
E. 11th St.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

12034

CERTIFICATE OF DEATH.

1-PLACE OF DEATH USA General Hospital No.2,

REGISTERED NO. C

CITY OF BALTIMORE: (No. Fort McHenry, Md.)

ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vernon S. Purnell, Major, F.A. Unassigned.

(Residence in Baltimore No. 2138 California St., Washington, D. C. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male	4-COLOR OR RACE, White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married (Write the word.)
-----------------------	----------------------------------	---

6-DATE OF BIRTH, Unknown (Month) (Day) (Year)	1 (Day) (Year)
--	--------------------------

7-AGE, 30 yrs. mos. ds.	If LESS than 1 day, ...hrs. or...min.?
--------------------------------------	---

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).	Regular Army Officer.
--	------------------------------

9-BIRTHPLACE, (State or Country),	Ill.
--------------------------------------	-------------

PARENTS.	10-NAME OF FATHER,	Unknown
	11-BIRTHPLACE OF FATHER (State or Country),	Unknown
	12-NAME OF MOTHER OF MOTHER	Mrs. Violet E. Purnell
	13-BIRTHPLACE OF MOTHER (State or Country),	Unknown,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed.....	APR 7 - 1920	ROBERT E. LAUTER
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MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 6, 1920 (Month) (Day) (Year)	1920 (Year)
---	-----------------------

17- I HEREBY CERTIFY, That I attended deceased from
November 22 1919, to **April 6, 1920**,
that I saw him alive on **April 6, 1920**,
and that death occurred, on the date stated above, at **10:35 A.M.**

The CAUSE OF DEATH* was as follows:
**Seminal epithe lioma with metastasis in
retro-peritoneal lymph glands & rt. kidney
Testicle removed.**

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration)..... yrs..... mos..... ds.
(Signed).... **Thomas J. Leary, Major, M.C.** M. D.
Apr. 6, 1920 (Address) **Ft. McHenry, Md.**

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds.	In the State..... yrs..... mos..... ds.
--	---

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Washington D. C.	April 7, 1920
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20-UNDERTAKEN ADDRESS 1127

May Johnson	1127
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CAUSE OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificate.

Spec. 1000 Bks.

D42035

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST.:

WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female colored Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Not known

6 DATE OF BIRTH (month, day, and year)

Mar 3 1894

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

26

1

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Fredericksburg Va.

10 NAME OF FATHER

Wm Manning

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

12 MAIDEN NAME OF MOTHER

Eddie Morrie

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

14

Informant (Address)

Lucy Morrie (Aunt) 107 Wansford St. Fredericksburg Va.

15

File

APR 7 - 1920

ROBERT F. KAUFMAN

Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH (month, day, and year)

4 / 6 / 1920

I HEREBY CERTIFY, That I attended deceased from

3 / 31 / 1920, to 4 / 6 / 1920,

that I last saw him alive on 4 / 5 / 1920,

and that death occurred, on the date stated above, at 3:20 a.m.

The CAUSE OF DEATH* was as follows:

Purpural Septicemia

(duration) yrs. mos. ds. 10

CONTRIBUTORY (Secondary) abortion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) J. W. H. Thompson M. D.

4/6, 1920 (Address) 1019 D. Hillman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Fredericksburg, Va.

Apr. 7 1920

20 UNDERTAKER

Jno. McElhenny

ADDRESS 1234 Ething St.

D42036

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1115* *Never* ST. *17* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1115* *Never* St. *6* yrs. *—* mos. *—* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*Colored*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Never*

6-DATE OF BIRTH,

1853
(Month) (Day) (Year)

7-AGE,

67 yrs. *—* mos. *—* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Samuel E. Bay*(Address) *916 O. Ave.*

15-

Filed *APR 7 - 1920*

ROBERT E. BAUTER

Burial Place Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr 5, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 10, 1918, to *Apr 5, 1920*,that I saw him alive on *Apr 4, 1920*,and that death occurred, on the date stated above, at *8:15 A. m.*

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(Duration) *2* yrs. *—* mos. *—* ds.CONTRIBUTORY
(Secondary)(Duration) *2* yrs. *—* mos. *—* ds.(Signed) *Frank C. Wagner* M. D.*Apr 7, 1920* (Address) *1006 Edmondson*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. John's**Apr 1, 1920*

20-UNDERTAKER

ADDRESS

*Samuel E. Bay**916 O. Ave.*

CAUSE OF DEATH IN plain terms on back of certificate. important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42037

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2430 Callow Ave.,

ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward C. Hennessy

(a) RESIDENCE No. 2430 Callow Ave.
(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 00 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 3, 1918

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
2 3 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ridley Park, Pa.
(State or country)

10 NAME OF FATHER Edward C. Hennessy

11 BIRTHPLACE OF FATHER (city or town) Jersey City
(State or country) N. J.

12 MAIDEN NAME OF MOTHER Helen E. Weaver

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)14 Informant Mrs. Helen C. Hennessy
(Address) 2430 Callow Ave.15 APR 7 - 1920 ROBERT F. CLAYTON
Burial Permit 0127

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5/20 19

17

I HEREBY CERTIFY, That I attended deceased from
March 22/20, 19, to 4/5/20, 19,
that I last saw him alive on 4 PM 4/5/20,

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis Throat neg. Diptheria

(Signed) Robert F. Clayton, M. D.

19 (Address) 29 E. Lexington Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

4/7 1920

20 UNDERTAKER

ADDRESS

Henry W. Mears & Son

805 Calver

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42038

CERTIFICATE OF DEATH.

120✓ D42038
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1320 W. Lombard St.; 19 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1320 W. Lombard St.; 25 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH.

Dec (Month) 13 (Day) 1861 (Year)

7-AGE.

58 yrs., 3 mos., 25 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE.
(State or Country),

Md

10-NAME OF FATHER,

William D. Dyer

11-BIRTHPLACE OF FATHER
(State or Country),

Pa

12-MAIDEN NAME OF MOTHER

Louise Wolf

13-BIRTHPLACE OF MOTHER
(State or Country),

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Marie Dyer

(Address)

1320 W. Lombard St.

15-

Filed

APR 7 - 1920

ROBERT R. EBAUTER

Burial Permit No. 10000.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 5, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 5, 1920, to April 5, 1920,

that I saw her alive on April 5, 1920,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(Duration) 2 yrs., mos., ds.CONTRIBUTORY
(Secondary)(Duration) yrs., mos., ds.

(Signed)

M. D. O'Neill

April 6, 1920 (Address) 108 N. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

London Park

DATE OF BURIAL.

April 11, 1920

20-UNDERTAKER

John Fields 1200 W. Lombard St.

CAUSE OF DEATH in plain terms, if important. See instructions on back of certificate.

D42039

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42039

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.: *18* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Claudie Walters*(a) RESIDENCE. No. *12 03 W Lombard* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *22* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *W. J. Walters*6 DATE OF BIRTH (month, day, and year) *Sept 14 1898*7 AGE *22* Years Months *6* Days *24* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)10 NAME OF FATHER *C W Holmes*11 BIRTHPLACE OF FATHER (city or town) *Ind* (State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Unknown* (State or country)14 Informant *University Path* (Address) *Green + Lombard*15 File *APR 7 - 1920* ROBERT E. BAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 7 1920*

17 I HEREBY CERTIFY, That I attended deceased from

4/6, 19*20*, to *4/7*, 19*20*.that I last saw him alive on *Apr 7*, 19*20*.and that death occurred, on the date stated above, at *12:00 a m.*

The CAUSE OF DEATH* was as follows:

Post Partum hemorrhage following retained placenta.(duration) yrs. mos. *5* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *C. K. Schneider*, M. D.*4/7*, 19*20* (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral

DATE OF BURIAL

April 19 1920

20 UNDERTAKER

John Fields *1200 W Lombard*

Information should be carefully supplied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D42040

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓
D42040
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1600 W Fayette* ST. *19* WARD)2-FULL NAME *Margaret G Schorf*(Residence in Baltimore: No. *1600 W. Fayette* St. *19* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *7*4-COLOR OR RACE, *W.*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *May 27, 1903*7-AGE, *16* yrs. *10* mos. *10* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *School*(b) General nature of industry, business, or establishment in which employed (or employer) *School*9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Robert Schorf*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*12-MAIDEN NAME OF MOTHER *Margaret Horn*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Margaret Schorf*(Address) *1600 W. Fayette St.*

15-APR 7 - 1920

ROBERT E. KRAUTER

Filed..... 191... *Baltimore* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 6, 1920*

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *March 25, 1920*, to *April 6, 1920*, that I saw her alive on *April 5, 1920*, and that death occurred, on the date stated above, at *8 a.* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *2* yrs.mos.ds.CONTRIBUTORY (Secondary) *Coronary Arteriosclerosis*(Duration) *2* yrs.mos.ds.(Signed) *Edward H. Coulahan*, M. D.*April 7, 1920*, (Address) *74 N. Fallis St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park*DATE OF BURIAL, *April 8, 1920*20-UNDERTAKER *John F. Fido*ADDRESS *1200 W. Lombard*

CAUSE OF DEATH in plain terms, so that it is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42041

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 29 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

APR 7 - 1920

ROBERT R. ERAUTER

Surgeon General

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan. 3 - 1920, to April 5 1920,

that I saw her alive on April 4 1920,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Bright Disease
Complication Disease
Epilepsy
(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 3 mos. ds.

(Signed)

April 5, 1920 (Address) 718 E. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

JAMES H. DENNIS

1303 FRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it can be understood by the layman. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42042

CERTIFICATE OF DEATH.

170

D42042

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3900 Hawthorne Ave.

ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Ann Chavannes

(a) RESIDENCE. No. 3900 Hawthorne Ave.

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 2, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Kingston Jamaica
(State or country) West Indies

10 NAME OF FATHER Robert J. Henderson

11 BIRTHPLACE OF FATHER (city or town) County Down
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Brown

13 BIRTHPLACE OF MOTHER (city or town) Kingston
(State or country) Jamaica14 Informant Frank J. Chavannes
(Address) 4214 Greenway15 File APR 7 - 1920 ROBERT A. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1920, to June 6, 1920, that I last saw h. ~~at~~ alive on April 6, 1920, and that death occurred, on the date stated above, at 8.4 m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Age

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? Yes

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Suppression

(Signed) John A. Baker M. D.

, 19 (Address) 101 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Druid Ridge Cem

Apr. 8 1920

20 UNDERTAKER

Joseph B. Cook

ADDRESS
1003 N. Balt
Street.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42043

D42043

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2801 W. North Ave.

ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Frances Cory

(a) RESIDENCE. NO. 2801 W. North Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Benjamin H. Cory

6 DATE OF BIRTH (month, day, and year) Aug. 18, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Rhode Island

10 NAME OF FATHER George Washington Cook

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Tiverton
Rhode Island

12 MAIDEN NAME OF MOTHER Carroll

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland U.S.14 Informant Dr. Herbert E. Cory
(Address) 2801 W. North Ave.15 APR 7 - 1920 ROBERT E. BRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1920

17 I HEREBY CERTIFY, That I attended deceased from April 2nd, 1920 to April 6th, 1920, that I last saw him alive on April 6th, 1920, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration)	yrs.	mos.	ds.
		4	

CONTRIBUTORY (Secondary) Asymptomatic

(duration)	yrs.	mos.	ds.
		1	

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?
(Signed) Wm J. Perkins, M. D.
, 19 (Address) 1 West Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Providence Rhode Island April 8, 1920

20 UNDERTAKER
Joseph B. Cook
ADDRESS
1103 N. Baltimore
Speed

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

D42044

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42044

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2437 Etting ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Delma Griffin

(a) RESIDENCE. NO.

2437 Etting

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

FemaleColoredSingle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

Feb 29/20

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Beth. Md.

10 NAME OF FATHER

Edward Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Jucy Brink

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa.

14

Informant (Address)

Edward Griffin
2437 Etting St.

15

APR 7 - 1920

ROBERT E. REAFTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 6 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr 3 1920, to Apr 6 1920,that I last saw her alive on Apr 5 1920,and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Bronch. Pneumonia(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No(Signed) E. William Frey, M. D.4/7, 1920 (Address) 1920 Pa. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Peter'sApril 8 1920

20 UNDERTAKER

ADDRESS

James E. Wright 1364 Maryland

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42045

CERTIFICATE OF DEATH

STILL B

D42045

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Johns Hopkins Hospital

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Ford

(a) RESIDENCE. NO.

1135 Myrtle Ave

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

c

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

✓

6 DATE OF BIRTH (month, day, and year)

Mch 29, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, 5 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

James Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Maggie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

W. W. Gray

15

APR 7 - 1920

ROBERT B. LEAUTE

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mch 29 1920

17

I HEREBY CERTIFY, That I attended deceased from

Mch 29, 1920, to Mch 29, 1920,

that I last saw him alive on Mch 29, 1920,

and that death occurred, on the date stated above, at 120 P. M.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W. Harris, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

19

20 UNDERTAKER

ADDRESS

APR 1 1920

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates.

D42016

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Johns Hopkins Hospital.

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Baker

(a) RESIDENCE. NO.

935 Park Ave.

ST.:

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mch 25, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or 18 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Charles Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mary Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

Informant (Address)

W. Gray

Johns Hopkins Hospital

15

MAR 27 1920 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mch 25, 1920

17

I HEREBY CERTIFY, That I attended deceased from

Mch 25, 1920, to Mch 25, 1920,

that I last saw him alive on Mch 25, 1920,

and that death occurred, on the date stated above, at 12:40 A. M.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

John W. Harris, M. D.

3/25, 1920

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

19

20 UNDERTAKER

Commissioner Health

ADDRESS

MAR 26 1920

Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42047

CERTIFICATE OF DEATH.

D42047

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Protestant Inf.* ST.; *17* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence, in Baltimore: No. *832 Harlem Ave* St.; *66* yrs., *6* mos., *16* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

October 22, 1854
(Month) (Day) (Year)

7-AGE,

66 yrs., 6 mos., 16 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Carpenter*
015

9-BIRTHPLACE, (State or Country).

Baltimore

PARENTS.

10-NAME OF FATHER,

Leibert Grey

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Mary Anne Keiser

13-BIRTHPLACE OF MOTHER (State or Country),

Cumtland Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *B.M. Gmel*(Address) *16 R.I.*

15-

Filed

APR 7 - 1920

ROBERT F. CHAUTIER

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 7, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 3, 1920, to April 7, 1920,
that I saw him alive on *April 6, 1920,*
and that death occurred, on the date stated above, at *3 A.M.*

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation(Duration) *about 10 min.*

CONTRIBUTORY (Secondary)

Mitral insufficiency(Signed) *Walter H. Hays* M.D.*H-7, 1920* (Address) *N. 4th St. N.Y.C.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the *66* yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *832 Harlem Ave.*

19-PLACE OF BURIAL, OR REMOVAL,

Louise

DATE OF BURIAL,

April 9, 1920

20-UNDERTAKER

Geo W Little

ADDRESS

531 N. ...

CAUSE OF DEATH—important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42048

CERTIFICATE OF DEATH.

45 D42048

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 S Brooking ST.: 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hellen M. A. Ryan(a) RESIDENCE. No. 335 S Brooking ST., 2 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced
HUSBAND of Thomas Ryan
(or) WIFE of6 DATE OF BIRTH (month, day, and year) April 20, 18807 AGE Years 39 Months 11 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Brighton
(State or country) Mo10 NAME OF FATHER John Monte11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER John13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)14 Informant Thomas Ryan
(Address) 335 S. Brooking15 APR 7 1920 ROBERT E. KAUTER
Registrar

Baptist Church

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5 1920

17 I HEREBY CERTIFY, That I attended deceased from

Nov 1, 1919, to Apr 5, 1920.that I last saw her alive on Mar 30, 1920.and that death occurred, on the date stated above, at 12 A m.

The CAUSE OF DEATH* was as follows:

Malignant tumor of ovary
lymphatic system
chronic
3 years (duration) 1 yrs. 10 mos. — ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? 1/2 Date ofWas there an autopsy? noWhat test confirmed diagnosis? clinical signs(Signed) E. H. Ryan, M. D., 19 (Address) 335 S. Brooking St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cern.Apr 8 1920

20 UNDERTAKER

ADDRESS

Wm. E. Blacke 427 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

D42049

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42049

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Med. Gen. Hospital* ST. *16* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Iola B. Dicus*(a) RESIDENCE. NO. *617 N. Schroeder*

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *48* yrs. *6* mos. *12* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced (husband or wife of) *Robert J. Dicus*6 DATE OF BIRTH (month, day, and year) *Sept 24 - 1876*7 AGE Years *43* Months *6* Days *12* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House Duties*(b) General nature of industry, business, or establishment in which employed (or employer) *At Home*

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Md.* (State or country)10 NAME OF FATHER *John Fritz*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Don't Know*13 BIRTHPLACE OF MOTHER (city or town) *Don't Know* (State or country)14 Informant *Robert J. Dicus* (Address) *617 N. Schroeder St**Robert F. Harrison,*

APR 7 - 1920

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 5 1920*17 I HEREBY CERTIFY, That I attended deceased from *Sept 13*, 1920, to *Apr 5*, 1920, that I last saw her alive on *Apr 5*, 1920, and that death occurred, on the date stated above, at *12.55 P.* m. The CAUSE OF DEATH* was as follows:*Chronic nephritis**stroke* (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cerebral hemorrhage (duration) yrs. mos. ds.18 Where was disease contracted *her residence* if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *urinalysis & blood*(Signed) *H. E. Krupp*, M. D.*45*, 1920 (Address) *1002 N. Zennvale*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL

DATE OF BURIAL

*London Park Cem**Apr 8 1920*

20 UNDERTAKER

ADDRESS

*Mr Mrs John W. Leufel**801 W. Fayette*

D42050

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

406 S Eden

ST.; 3 WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Domestic Fiesca

(Residence in Baltimore: No.

406 S Eden

St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

M

4-COLOR OR RACE,

W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH.

June

15

1871

(Month)

(Day)

(Year)

7-AGE,

49

yrs.

9

mos.

22

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Labor

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Italy

10-NAME OF FATHER,

Anthony Fiesca

11-BIRTHPLACE OF FATHER (State or Country),

Italy

12-MAIDEN NAME OF MOTHER

Mary Fiesca

13-BIRTHPLACE OF MOTHER (State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Angeline Fiesca

(Address).....406 S Eden

15-

Robert P. Harrison,

Filed

191

APR 7 - 1920

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April

6, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 10, 1919, to March 1920,

that I saw him alive on 191

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Coronary artery
Endocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cholera

(Duration) 2 yrs. mos. ds.

Signed: Marshall L. Mason, M. D.

4/7/20, 191... (Address) 311 S. 13th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St Vincent

DATE OF BURIAL.

April, 1920

20-UNDERTAKER

Mendell Duffel & Son

ADDRESS

311 S. 13th St.

D42051

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42051

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 Kanawha ST.; 23 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1531 Kanawha St.; 23 yrs., 0 mos., 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Married

6-DATE OF BIRTH.

Month March, Day 13, Year 1896
(Month) (Day) (Year)

7-AGE.

74 yrs., 0 mos., 28 ds.If LESS than 1 day,
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Free Rock

9-BIRTHPLACE,
(State or Country),

Baltimore Md

PARENTS.

10-NAME OF FATHER,

Albert A. Pierson

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore Md

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Weaver(Address) 1531 Kanawha St.

15-

Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Month Apr, Day 6, Year 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mar 30 1920, to Apr 6 1920,that I saw her alive on Apr 5 1920,and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis(Duration) 4 yrs., 3 mos., 4 ds.CONTRIBUTORY
(Secondary)(Duration) 3 yrs., 3 mos., 4 ds.(Signed) J. Harrison M. D.4/7/20 (Address) 1531 Kanawha St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 yrs., 3 mos., 4 ds. In the State 4 yrs., 3 mos., 4 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Mount Olivet CemApril 9, 1920

20-UNDERTAKER

ADDRESS

B. Schuman & SonKanawha St.

APR 7 - 1920

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42052

CERTIFICATE OF DEATH

119 ✓
REGISTERED NO. D42052

PLACE OF DEATH

CITY OF BALTIMORE (No. 1608 Alecanna St.)

ST. 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Jones

(Residence in Baltimore: No. 1608 Alecanna St.)

St. 53 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE Negro 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6-DATE OF BIRTH Unknown, 1 (Month) (Day) (Year)

7-AGE 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work Horseless (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

Baltimore City

10-NAME OF FATHER

Thomas Jones

11-BIRTHPLACE OF FATHER (State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Florence Jones

(Address)

1608 Alecanna St.

15.

APR 8 - 1920

ROBERT B. FRAUTER

Burial Place: REPOSE

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH April 5, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1920, to April 5, 1920, that I saw him alive on April 5, 1920, and that death occurred, on the date stated above, at 7 P. M. The CAUSE OF DEATH* was as follows:

Acute Peritonitis

Contributory (SECONDARY)

(Duration) yrs. mos. ds. 8

(Signed)

April 7, 1920

(Address)

1720 Linden St. M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds. In the

Where was disease contracted.

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Laurel

DATE OF BURIAL

April 8, 1920

20-UNDERTAKER

John W. Henderson & Monument

N. B.-Every item of information should be carefully supplied. If not known, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42053

CERTIFICATE OF DEATH.

91-079 D42053

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 Edmonson Ave ST.: 19 WARD)

2-FULL NAME

Kelburn D. French -

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE

No 1707 Edmonson Ave ST.: 19 WARD.

Whitefield N. H.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Martha French

6 DATE OF BIRTH (month, day, and year)

Feb 5-1842

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

78

2

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Wheelwright

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Himself

9 BIRTHPLACE (city or town) (State or country)

New Hampshire

10 NAME OF FATHER

James French

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Whitefield N. H.

12 MAIDEN NAME OF MOTHER

Julia Dunsen

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Whitefield N. H.

14

Informant (Address)

Barnard J. French 1707 Edmonson Ave

15

APR 8 - 1920

ROBERT E. KHAUFER Registrar

Serial Permit 0107

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th 1920.

17

I HEREBY CERTIFY, That I attended deceased from

April 1st, 1920, to April 7th, 1920.that I last saw him alive on April 7th, 1920.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia - terminant in uraemia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary)

Myocarditis

(duration) many yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Howard Wilson, M. D.

47, 1920 (Address)

45 Preston St, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Whitefield N. H.

April 8 1920

20 UNDERTAKER

ADDRESS

J. B. Cook

1003 M. Balto

CAUSE OF DEATH in plain terms, so that it can be understood by laymen. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42054

CERTIFICATE OF DEATH.

155 D42054

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Md. Gen. Hospital*)ST.: *13* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mr. Emory J. Hipple

(a) RESIDENCE. NO.

837 W. 34th

ST.

WARD. *Mayville Pa*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*White*5 ~~Single, Married, Widowed,~~~~or Divorced (write the word)~~*Widowed*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Mary Hipple*

6 DATE OF BIRTH (month, day, and year)

April 14, 1859

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*60**11**24*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Pa*

10 NAME OF FATHER

William Hipple

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pa

12 MAIDEN NAME OF MOTHER

Mary Siler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Pa

14

Informant

(Address)

*Marion Robinson
837 W. 34th St*

15

*APR 8 - 1920**ROBERT E. KEATINGE*

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH (month, day, and year) *Apr. 7* 19*20*I HEREBY CERTIFY, That I attended deceased from *Apr. 3*, 19*20*, to *Apr. 7*, 19*20*.that I last saw him alive on *Apr. 7*, 19*20*.and that death occurred, on the date stated above, at *10:10 a. m.*

The CAUSE OF DEATH* was as follows:

Poisoned by bichloride, probably suicidal.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

8 Where was disease contracted *837 W. 34th St.*
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *none*What test confirmed diagnosis? *Urinalysis*(Signed) *H. E. Wright*, M. D.Th, 1920 (Address) *Md. General Hospital.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mayville Pa April 8, 1920

20 UNDERTAKER

*Chenoweth & son**3615 Chelmsford*

CAUSE OF DEATH in plain terms, so that it can be understood by laymen. See instructions on back of certificates.

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 308 N. Biddle ST.; 11 WARD)

2-FULL NAME

(Residence in Baltimore: No. 308 W. Biddle St. 15 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

4-COLOR OR RACE.

5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

C-DATE OF BIRTH.

Feb. 5, 1894
(Month) (Day) (Year)

7-AGE,

26 yrs. 2 mos. — ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Cook.....v!

9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER.

**11-BIRTHPLACE
OF FATHER
(State or Country).**

12-MAIDEN NAME
OF MOTHER

**13-BIRTHPLACE
OF MOTHER
(State or Country).**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- APR 8 - 1920 ROBERT R KRAUTER

Filed....., 1918. Received.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

April 5, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
Oct. 15th 1914, to April 1914,
that I saw her alive on April 2nd 1914,
and that death occurred, on the date stated above, at 7:11 a.m.
The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)..... M. D.

4-6-..., 1920. (Address) 924 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42056

CERTIFICATE OF DEATH.

150 ✓
REGISTERED No. C

D42056

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Provident Hospital* ST. *11* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. _____ St. _____ yrs., _____ mos., _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Married

6-DATE OF BIRTH

April 6th 1920
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day,
_____ yrs. _____ mos. _____ ds. *12 hrs. or less*

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),*Baltimore*

PARENTS.

10-NAME OF FATHER,

Benjamin Finney

11-BIRTHPLACE OF FATHER

(State or Country),

MD

12-MAIDEN NAME OF MOTHER

Gertrude Finney

13-BIRTHPLACE OF MOTHER

(State or Country),

MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Gertrude Finney*(Address) *927 Pierce St*

15-

Filed *APR 8 - 1920*

ROBERT E. KRAUTER

BUREAU OF VITAL REGISTRATION

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr 4th 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr 4th 1920, to *Apr 7th 1920*,that I saw her alive on *Apr 4th 1920*,and that death occurred, on the date stated above, at *5:30* m.

The CAUSE OF DEATH* was as follows:

*Failure of Closure of Foramen
Ovale*

(Duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Harrold Brown*

M. D.

Apr 7, 1920 (Address) *1501 Presbiterian*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Ambrose Cemetery

DATE OF BURIAL,

Apr 8, 1920

20-UNDERTAKER

Samuel H. Hensley 578 W. Biddle St

D42057

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D42057

PLACE OF DEATH

CITY OF BALTIMORE (No. 1320 Hollins Street. ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laurence A. Selby.

(Residence in Baltimore: No. 1320 Hollins Street. Sr. 58 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married. (Write the word)

6 DATE OF BIRTH October 31st, 1845. (Month) (Day) (Year)

7 AGE 74 yrs. 5 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Retired E. & O. Engineer (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Poplar Springs Md

10 NAME OF FATHER Caleb Selby.

11 BIRTHPLACE OF FATHER (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Rachael W. Buckingham.

13 BIRTHPLACE OF MOTHER (State or country) Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Pessie Mitchell (daughter)

(Address) 1617 N. Payson Street.

15 APR 8 - 1920

Filed

191

ROBERT R. KRAUTER

Burial Place REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 6th, 1920. (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1920, 191 to April 6, 1920, 191

that I saw him alive on April 6th, 1920, 191 and that death occurred, on the date stated above, at 11 a.m. The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) --- yrs. --+ mos. 3 ds

Contributory (SECONDARY) (Signed) Otto M. Reinhardt M. D. April 7, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death --- yrs. --- mos. --- ds. In the State --- yrs. --- mos. --- ds.

Where was disease contracted?

If not at place of death?

*Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Druid Ridge

DATE OF BURIAL

4/9 1920

20 UNDERTAKER

J. F. W. McCully

ADDRESS

130 E. Fort

N. B. Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42058

CERTIFICATE OF DEATH.

79 D42058

1-PLACE OF DEATH

CITY OF BALTIMORE, NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced, HUSBAND or WIFE of *Bertha Thompson*

6 DATE OF BIRTH (month, day, and year) *April 1920*

7 AGE Years *26* Months *-* Days *-* If LESS than 1 day. hrs. *-* or min. *-*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15 APR 8 - 1920

ROBERT E. LEAUTEA

Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/7/1920*

17

I HEREBY CERTIFY. That I attended deceased from *March 27th* 19*20* to *April 7th* 19*20*, that I last saw him alive on *April 6th* 19*20*, and that death occurred, on the date stated above, at *2A* m.

The CAUSE OF DEATH* was as follows:

Nitrat Regurgitation

CONTRIBUTORY

Cardio Vascular disease

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

473019 Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D42059

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D42059

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

Mercy Hospital
 Ellen Bradford
 1919 Curran St.

St.: 9

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

APR 8 - 1920

ROBERT B. KRAUTER

Burial Permit No.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

Septicemic Aortitis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed)

(Coroner.)

Apr. 7, 1920 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

20-UNDERTAKER

Mrs. H. A. Elliott

DATE OF BURIAL,

Apr. 8, 1920

ADDRESS

1735 Ashland Ave.

N.B.—Every return must be filled out in plain terms, so that it may be properly understood. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42060

CERTIFICATE OF DEATH.

79 D42060
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1408 August* ST.; *9* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1408 August St.* St.; *39* yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Female</i>	4-COLOR OR RACE. <i>White</i>	5-MARRIAGE STATUS. <i>Widow</i> (Write the word.)
-------------------------	----------------------------------	---

6-DATE OF BIRTH. <i>Aug 9</i> (Month) (Day) (Year)	<i>1833</i> (Year)
--	-----------------------

7-AGE. <i>86</i> yrs. <i>7</i> mos. <i>28</i> da.	If LESS than 1 day, ...hrs. or...min.?
--	---

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).	<i>Housekeeper</i>
--	--------------------

9-BIRTHPLACE. (State or Country).	<i>Pennsylvania</i>
--------------------------------------	---------------------

PARENTS.	10-NAME OF FATHER.	<i>Benjamin Elough</i>
	11-BIRTHPLACE OF FATHER (State or Country).	<i>Pennsylvania</i>
	12-MAIDEN NAME OF MOTHER	<i>Charlotte Morris</i>
	13-BIRTHPLACE OF MOTHER (State or Country).	<i>Md.</i>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harry Stranberg*(Address) *1408 August St.*

APR 8 - 1920

ROBERT E. LAUTER

Filed..... 191..

SPECIAL PERMIT TO SIGN

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. <i>April 7</i> (Month) (Day) (Year)	<i>1920</i> (Year)
---	-----------------------

17- I HEREBY CERTIFY, That I attended deceased from *Oct 10* 1919, to *Apr 7* 1920, that I saw her alive on *March 7* 1920, and that death occurred, on the date stated above, at *3:30 A.M.*

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration).....yrs.....mos.....da.

CONTRIBUTORY.....
(Secondary)

(Signed) *Leontine M. Baker* M. D.
Apr 7 1920 (Address) *1114 N. ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

London Park Cemetery

DATE OF BURIAL.

Apr 9 1920

20-UNDERTAKER

Henry Hocklin

ADDRESS

1301 E. Eager St.

D42061

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D42061

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1834 E Chase* ST.: *8* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Dorothy Schmick(a) RESIDENCE. NO. *1834 E Chase* ST. *8* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *27* yrs. *—* mos. *—* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Arnold J. Schmick*6 DATE OF BIRTH (month, day, and year) *January 1893*7 AGE Years *27* Months *2* Days *—* If LESS than 1 day, hrs. *—* or min. *—*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balt. Md.*
(State or country)10 NAME OF FATHER *William B. Newman*11 BIRTHPLACE OF FATHER (city or town) *Balt. Md.*
(State or country)12 MAIDEN NAME OF MOTHER *Emma Weiss*13 BIRTHPLACE OF MOTHER (city or town) *Balt. Md.*
(State or country)14 Informant *Mrs W. B. Newman*
(Address) *1834 E Chase*15 Filed *APR 8 1920* *ROBERT B. ELAUTER*
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 7 1920*17 I HEREBY CERTIFY, That I attended deceased from *July 1*, 19*20*, to *Apr 7*, 19*20*, that I last saw her alive on *Apr 6*, 19*20*, and that death occurred, on the date stated above, at *8:20* a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(duration) yrs. *10* mos. *—* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Don't know*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Autopsy*(Signed) *W. B. Newman*, M. D.19 (Address) *134 E. Charles*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer Cemetery

DATE OF BURIAL

Apr. 10 1920

20 UNDERTAKER

Henry Wood Lee

ADDRESS

1301 E. Eager St.

CAUSE OF DEATH IN PAIR CASES, See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42062

CERTIFICATE OF DEATH.

1542062

1-PLACE OF DEATH

West End Maternity

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Marie Elizabeth Weston

(Residence in Baltimore: No.

532 E. Eulton Ave

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Single

6-DATE OF BIRTH,

April 6, 1922
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day,

yrs. mos. ds.

5 hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Home, old

9-BIRTHPLACE,
(State or Country),

Maryland

10-NAME OF FATHER,

William Weston

11-BIRTHPLACE OF FATHER
(State or Country),

Michigan

12-MAIDEN NAME OF MOTHER

Marie Caldera

13-BIRTHPLACE OF MOTHER
(State or Country),

New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

William Weston

(Address)

532 E. Eulton Ave

15-

APR 8 - 1920

ROBERT E. BRAUTER

Filed

191

Burial Permit

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 7, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 6, 1922, to April 7, 1922,

that I saw her alive on April 6, 1922,

and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Pulmonary edema

(Duration) yrs. mos. ds.

(Signed) Bernard J. Quinn, M. D.

April 7, 1922 (Address) 1034 E. Eulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Gondor Park

Apr. 8, 1920

20-UNDERTAKER

ADDRESS

George C. Schwaib, 210 E. Eulton Ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42063

CERTIFICATE OF DEATH.

96 D42063
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 336 S. Poppleton ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 336 S. Poppleton St.; 32 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED, Married

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH.

April 7, 1888
(Month) (Day) (Year)

7-AGE.

32 yrs., mos., ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife9-BIRTHPLACE,
(State or Country),Baltimore

10-NAME OF FATHER,

Geo. Tyson11-BIRTHPLACE OF FATHER
(State or Country),Md.

12-MAIDEN NAME OF MOTHER

Mrs. Smith13-BIRTHPLACE OF MOTHER
(State or Country),Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Paul Carroll(Address) 336 S. Poppleton St.

15-APR 8 - 1920

ROBERT B. KRAUTER

Filed..... 191.....

Burial Place Registration

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

April 7, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Apr. 5, 1920, to Apr. 7, 1920, that I saw her alive on Apr. 7, 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute tubercle of the heart

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY... Arteriosclerosis
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) J. M. [illegible] M. D.Apr. 8, 1920 (Address) 729 [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Unionopolis Md.

DATE OF BURIAL,

Apr. 10, 1920, 191...

20-UNDERTAKER

John J. Brown & Son, York, Pa.

ADDRESS

D42064

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C. 40 D42061

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2218 Walbrook Ave. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2218 Walbrook Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male
4-COLOR OR RACE. white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married (Write the word.)

6-DATE OF BIRTH. Jan 20th, 1872
(Month) (Day) (Year)

7-AGE. 48 yrs. 2 mos. 18 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. New Adm.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, Thomas M. Sherrard

11-BIRTHPLACE OF FATHER, Baltimore
(State or Country)

12-MAIDEN NAME OF MOTHER, Annie L. Lyles

13-BIRTHPLACE OF MOTHER, Baltimore
(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. J. Lyles

(Address) 2218 Walbrook Ave.

APR 8 - 1920 Robert F. Harrison,
Filed 191 Registrar.

Burial Permit Clerk

Baltimore

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 7th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 26th 1920, to April 7th 1920, that I saw him alive on April 6th 1920, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach -
(Duration) 5 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. E. Harrison M. D.

April 7th, 1920 (Address) 1227 W. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral

DATE OF BURIAL, April 10, 1920

20-UNDERTAKER, Martin L. Lyles

ADDRESS, 1227 W. Baltimore

important. See instructions on back of certificate.

D42065

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42065

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Howard G. Kelly Hospital* St.; *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Katie May Waggoner(Residence in Baltimore: No. *Howard G. Kelly Hospital* St.; *1* yrs., *1* mos., *23* ds.)*1418 Eutaw Place*

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

Nov-22, 1876
(Month) (Day) (Year)

7-AGE,

43 yrs., *4* mos., *17* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housewife*

9-BIRTHPLACE, (State or Country),

Texas

10-NAME OF FATHER,

D. F. Davis

11-BIRTHPLACE OF FATHER (State or Country),

Illinois

12-MAIDEN NAME OF MOTHER

Pauline Allen

13-BIRTHPLACE OF MOTHER (State or Country),

Indiana

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *K. Waggoner*(Address) *Wichita Falls, Texas*

15-

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 8, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Feb. 14, 1920*, to *April 8, 1920*, that I saw her alive on *April 8, 1920*, and that death occurred, on the date stated above, at *7:15* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Primary M. of Cervix, with abdominal metastases, over 2 years.
(Duration) *2* yrs., *1* mos., *23* ds.

CONTRIBUTORY (Secondary)

Chronic heart disease
(Duration) *1* yrs., *1* mos., *23* ds.(Signed) *Robert A. Roberts, M. D.**April 8, 1920* (Address) *1418 Eutaw Place*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *0* yrs., *1* mos., *23* ds. In the State *0* yrs., *1* mos., *23* ds.

Where was disease contracted, if not place of death?

Former or usual residence *Wichita Falls, Texas*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Wichita Falls, Texas *April 8, 1920*

20-UNDERTAKER

ADDRESS

Chas. G. Black 742 W. Northway

important. See instructions on back of certificate.

APR 8 - 1920

D42066

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42066

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 638 Franklin Ave ST.: 17 WARD)2-FULL NAME Patrick Henry O'Neill(a) RESIDENCE. NO. 638 W. Franklin ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17 18657 AGE Years 54 Months 9 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Hanger(b) General nature of industry, business, or establishment in which employed (or employer) Wall Paper(c) Name of employer J. G. Valiant9 BIRTHPLACE (city or town) Barto (State or country) Ind10 NAME OF FATHER Patrick O'Neill11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)12 MAIDEN NAME OF MOTHER Ann R. Riordan13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)14 Informant John S. Medairy (Address) 1724 N. Charles St.Robert F. Harrison,

APR 8 - 1920

Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 192017 I HEREBY CERTIFY, That I attended deceased from Apr 6th, 1920, to Apr 6, 1920, that I last saw him alive on Apr 6, 1920, and that death occurred, on the date stated above, at 8.45 P m. The CAUSE OF DEATH* was as follows:Aortic Aneurism(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? none(Signed) Austad Tolman, M. D., 19 (Address) 656 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Frederick Park Cemetery April 8 1920

20 UNDERTAKER

W. M. Rouse ADDRESS 230 N. Main

CAUSE OF DEATH in plain terms, so that it can be understood by the layman. See instructions on back of certificates. TION is very important.

D42067

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42067

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Mount Hope Retnat

ST.: 189 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Joseph Ott

(Residence in Baltimore: No.

Formerly 1837 W. Pratt St

St.: 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male	4-COLOR OR RACE. White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
6-DATE OF BIRTH. Not Known 185-9 (Month) (Day) (Year)		
7-AGE. 61 yrs. 0 mos. 0 ds.		If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE. (State or Country), Germany		
PARENTS.	10-NAME OF FATHER. George Ott	
	11-BIRTHPLACE OF FATHER (State or Country), Germany-Bavaria	
	12-MAIDEN NAME OF MOTHER Not Known	
	13-BIRTHPLACE OF MOTHER (State or Country), Not Known	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jacob Ott

(Address)

717 W. Lombard St

15-

Robert F. Harrison

Filed

APR 8 - 1920

191

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 7th 1920 (Month) (Day) (Year)	17- I HEREBY CERTIFY, That I attended deceased from May 1890 191, to April 7th 1920 that I saw h. alive on April 6th 1920 and that death occurred, on the date stated above, at 10:20 a.m. The CAUSE OF DEATH* was as follows: Chr. Interstitial Nephritis Chb. (Duration) 4 yrs. 0 mos. 0 ds. CONTRIBUTORY. Terminal Dementia - Post (Secondary) abt Melancholia (Duration) 31 yrs. 0 mos. 0 ds. (Signed) Frank J. Flannery M. D. Apr 7th 1920 (Address) Mt Hope Retnat
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*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 31 yrs. 0 mos. 0 ds. In the 31 yrs. 0 mos. 0 ds. State

Where was disease contracted, Baltimore Md
if not at place of death?

Former or usual residence Baltimore Md

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem	DATE OF BURIAL, April 8, 1920
20-UNDERTAKER Jas Pendersen Son	ADDRESS 217 S. Paca

important. See instructions on back of certificate.

D42068

HEALTH DEPARTMENT—CITY OF BALTIMORE D42068

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1837 Linden ave* ST. *14* WARD) *120*

REGISTERED NO. C

2-FULL NAME *Dr. William S. Norris*(Residence in Baltimore: No. *1837 Linden ave* St. *45* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH,

July 1, 1849
(Month) (Day) (Year)

7-AGE,

70 yrs. mos. ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Dentist*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Md

10-NAME OF FATHER,

Caleb Norris

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

May E. Penn

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Marj A. Norris*
(Address) *1837 Linden ave*

15-

Filed

Robert F. Harrison

191

Registrar.

Bureau Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 8, 1929
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from 1914, to *April 8* 1929, that I saw him alive on *April 8* 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Edema of Lungs

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Chronic Nephritis

(Duration) ... yrs. ... mos. ... ds.

(Signed) *E. Norris* M. D.4/8, 1929 (Address) *1733 Linden ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Green Mount

DATE OF BURIAL,

April 10, 1929

20-UNDERTAKER

John O. Mitchell 12011 Fayette St

ADDRESS

D42069

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42069

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1340 Penna. Ave. ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1340 Penna. Ave. ST., 17 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of Mary A. Hubbard (or) WIFE of6 DATE OF BIRTH (month, day, and year) 1868 Feb.7 AGE 57 Years Months 7 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balt. Ind.9 BIRTHPLACE (city or town) (State or country) Balt. Ind.10 NAME OF FATHER Geo. F. Hubbard11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind.12 MAIDEN NAME OF MOTHER Mary F. Todd13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind.

14

Informant (Address) Mary F. Hubbard15 Filed Robert F. Harrison, Registrar

16

17

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1920

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1920, to April 7, 1920, that I last saw him alive on April 6, 1920, and that death occurred, on the date stated above, at 7 A. m. The CAUSE OF DEATH* was as follows:Chronic Interstitial NephritisCONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. 6 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John G. Stifel, M. D.4/8, 1920 (Address) 206 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery April 9, 1920

20 UNDERTAKER

ADDRESS

John Oratchell 206 N. Fulton Ave.

CAUSE OF DEATH is very important. See instructions on back of certificates.

D42070

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42070

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 126 N. Calhoun St.

St. 19

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street, ad number and fill out No. 18.)

2-FULL NAME Elizabeth Vonkleiser

(Residence in Baltimore: No. 126 N. Calhoun St.

St. 38 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, March 11, 1848 (Month) (Day) (Year)

7-AGE, 72 yrs., 27 mos., ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Domestic (b) General nature of industry, business, or establishment in which employed (or employer), 07c

9-BIRTHPLACE, (State or Country), West Virginia

10-NAME OF FATHER, Theophil Vonkleiser

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dorothy Flamm

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Filbert

(Address) 126 N. Calhoun St.

15-

Robert P. Harrison,

Filed 8.19.20

191

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, APR. 7, 1920, 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

Inquiry and that said deceased came to death (Inquest, au- topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. Edward Smith, M. D. (Coroner) 4/8 1920 (Address) 910 Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Druid Ridge April 9, 1920

20-UNDERTAKER ADDRESS

John C. Mitchell 1201 N. Calhoun St.

D42071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J. Lilly

(a) RESIDENCE. NO. Unknown

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 80

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Constable

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records

(Address) New City Hospital.

15 Filed 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 1920

17 I HEREBY CERTIFY, That I attended deceased from February 13, 1915 to April 5, 1920, that I last saw him alive on April 5, 1920, and that death occurred, on the date stated above, at 10:55 P.m. The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY Arterio-sclerosis (Secondary)

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test

(Signed) R. P. Harrison, M. D.

Apr. 6, 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

19

20 UNDERTAKER

ADDRESS

Commissioner Health,

APR 3 1920

CAUSE OF DEATH in plain terms, as far as possible, on back of certificate. See instructions on back of certificates.

D42072

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42072

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *616 Lennox*ST.: *13* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elizabeth Ochs

(a) RESIDENCE. NO.

4714 Groveland Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

74 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Widow</i>
------------------------	---------------------------------	--

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Frederick Ochs*

6 DATE OF BIRTH (month, day, and year)

Apr 2-1846

7 AGE

Years

Months

Days

If LESS than
1 day. hrs.
or min.*74**—**6*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*At Sea*

10 NAME OF FATHER

*Fred Koch*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Germany*

12 MAIDEN NAME OF MOTHER

*Eliz. Fehling*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Germany*

14

Informant
(Address)*Amelia Koenig
4714 Groveland Ave*

15

Filed

19

APR-8 1920

Robert F. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 8 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

April 7th, 19*20*, to *April 7th*, 19*20*,that I last saw her alive on *April 7*, 19*20*,and that death occurred, on the date stated above, at *3:20* a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Arterial Sclerosis*

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *John Leonard Brady*, M. D., 19 (Address) *1900 Maryland Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Woodlawn Cem.**April 10* 19*20*

20 UNDERTAKER

Harry W. Ehlert

ADDRESS

1944 W. North Ave.

D42073

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42073

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 642 S StreeterST.: 1

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Virginia Rowles(a) RESIDENCE. No. 642 S Streeter

(Usual place of abode)

ST.: 1

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 11mos. 18ds. 18

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) April 20 1919

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.1118

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)BaltimoreMd10 NAME OF FATHER Wm M. Rowles

11 BIRTHPLACE OF FATHER (city or town)

A A Co

(State or country)

Md12 MAIDEN NAME OF MOTHER Agnes V. Duvall

13 BIRTHPLACE OF MOTHER (city or town)

A A Co

(State or country)

Md

14

Informant
(Address)William M. Rowles
642 S Streeter St

15

Filed

19 Robert P. Harrison,

Registrar

APR-8 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 7, 1920, to April 7, 1920that I last saw her alive on April 7, 1920and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia(duration) yrs. mos. 3 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) C. L. Long, M. D.4/8, 1920 (Address) 2701 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Maryothy ChurchAPR -9 1920

20 UNDERTAKER

JOHN F. DENNY

ADDRESS

716 LIGHT ST

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42074

D42074

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 157 ColvinST.: 5

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles B. Nelson(a) RESIDENCE. No. 157 Colvin

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. — mos. — ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Widowed

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

74

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Port Deposit, Md
Baltimore, Md

10 NAME OF FATHER

Henry Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Port Deposit, Md

12 MAIDEN NAME OF MOTHER

Mary Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Port Deposit, Md

14

Informant (Address)

Carrie B. Nelson
157 Colvin St

15

APR-9-1920

ROBERT R. ELLIOTT

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1920

17

I HEREBY CERTIFY, That I attended deceased from

4/6, 1920, to 4/7, 1920,that I last saw him alive on April 6, 1920,and that death occurred, on the date stated above, at 2:50 p m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

General Debility

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Balts - MdDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) J. O. Brown M. D.

47, 1530 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

National Cemetery April 9 1920

20 UNDERTAKER

ADDRESS

Mrs A A Elliott 1725Ashland

TION is very important. See instructions on back of certificates.

D42075

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42075

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2108 Fleet*ST.: *1*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Josephine Telak*(a) RESIDENCE. NO. *2108 Fleet*

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *19 March 1918*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*2**-**20*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Baby

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Stanislaus Telak

11 BIRTHPLACE OF FATHER (city or town)

Poland

(State or country)

12 MAIDEN NAME OF MOTHER

Alexandra Jarzinski

13 BIRTHPLACE OF MOTHER (city or town)

Poland

(State or country)

14

Informant (Address)

Stanislaus Telak
2108 Fleet

15

APR 9 - 1920

ROBERT A. ERAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 8" 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr 7" 1920, to *Apr 8" 1920*,that I last saw her alive on *Apr 7" 1920*,and that death occurred, on the date stated above, at *1 A. M.*

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

Joseph H. Kowalski, M. D.

198' 1920 Address)

2129 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary Cemetery

20 UNDERTAKER

ADDRESS

*E. W. Conklin**934 E. Gay St.*

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42076

CERTIFICATE OF DEATH.

D42076

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 E Hoffman ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1100 E Hoffman St.; 14 yrs., 8 mos., 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Single

6-DATE OF BIRTH,

July 20, 1909
(Month) (Day) (Year)

7-AGE,

10 yrs., 8 mos., 16 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).School9-BIRTHPLACE,
(State or Country),Baltimore Mo

PARENTS.

10-NAME OF FATHER,

Edw F Walz11-BIRTHPLACE OF FATHER
(State or Country),Balt Mo

12-MAIDEN NAME OF MOTHER

Mary Hebler13-BIRTHPLACE OF MOTHER
(State or Country),Balt Mo

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Walz(Address) 1100 E Hoffman

15-

APR 9 - 1920 ROBERT A. LAUTER
Filed..... 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 6, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Oct 1 1919, to Apr 6 1920,
that I saw her alive on April 6 1920,
and that death occurred, on the date stated above, at 4 PM.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
(Duration) 7 yrs., 7 mos., 7 ds.CONTRIBUTORY
(Secondary)(Duration) 7 yrs., 7 mos., 7 ds.(Signed) Joseph E. Murphy M. D.Apr 7, 1920 (Address) 1520 H. H. Hall

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer Church April 9 1920

20-UNDERTAKER

ADDRESS

E. A. Macfeldt 2113 Greenmount Ave

important. See instructions on back of certificate.

D42077

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D42077
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Smith

(a) RESIDENCE. No. 1213 Orlean St.

(Usual place of abode)

ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE

71

Years

Months

Days

If LESS

1 day

or

Unknown

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town) Virginia
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14

Informant Hospital Records

(Address) New City Hospital.

15

APR 9 - 1920 ROBERT E. LEBLON

BRIAN P. SMITH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 5, 1920, to April 6, 1920,

that I last saw him alive on April 5, 1920,

that death occurred, on the date stated above, at 4:10 A. M.

CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. T. Pessel, M. D.

Apr. 6, 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Ashbury Cemetery

Apr. 9 1920

20 UNDERTAKER

Chris. N. Johnson 414 York St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42078

CERTIFICATE OF DEATH.

92 D42078

PLACE OF DEATH

CITY OF BALTIMORE (No. 217 N. Mount St.

St.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Townes

(Residence in Baltimore: No.

217 N. Mount St.

Life St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male	4-COLOR OR RACE. Colored	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single (Write the word.)
6-DATE OF BIRTH. Aug. 1, 1919 (Month) (Day) (Year)		
7-AGE. yrs. 8 mos. 6 ds.		If LESS than 1 day. hrs. or min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE. (State or Country) Baltimore		
PARENTS.	10-NAME OF FATHER. Unknown	
	11-BIRTHPLACE OF FATHER. (State or Country). Unknown	
	12-MAIDEN NAME OF MOTHER. Madge Towns	
	13-BIRTHPLACE OF MOTHER. (State or Country). Md.	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Thomas

(Address) 217 N. Mount St.

15-APR 9 - 1920 ROBERT A. KRAUTER

Filed. 191. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr. 7, 1920 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

Inquiry find that said deceased came to his death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. C. W. M. D.

(Coroner)

(Address) 708 Light St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

At home, April 9, 1920

20-UNDERTAKER ADDRESS 114 W.

Brown & Schodder

CAUSE OF DEATH in plain text, so that it may be properly important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42079

CERTIFICATE OF DEATH.

D42079

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Ardinimo(a) RESIDENCE. NO. 424 S. Caroline St. ST. 3 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town)
(State or country)Italy10 NAME OF FATHER Antonio Ardinimo

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy12 MAIDEN NAME OF MOTHER Lucia Manzina

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy14 Informant Hospital Records(Address) M.T.H.15 APR 9 - 1920

ROBERT E. FRAUTER

Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 192017 I HEREBY CERTIFY, That I attended deceased from
July 28, 1919 to April 7, 1920,that I last saw him alive on April 7, 1920,and that death occurred, on the date stated above, at 11.15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 2 yrs. 2 mos. ds.CONTRIBUTORY Empyema
(Secondary)(duration) 2 yrs. 2 mos. ds.

18 Where was disease contracted

if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum.(Signed) George R. Williams, M. D.4-7-20 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mount Carmel Cemetery April 10 1920

20 UNDERTAKER

George J. Routh 1735 Haydon Ave

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42080

CERTIFICATE OF DEATH.

152

D42080

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 E. Hoffman

ST.; 9th WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry S. Gordon

(Residence in Baltimore: No. 729 E. Hoffman

St.; yrs., mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male	4-COLOR OR RACE, White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single
----------------	---------------------------	---

6-DATE OF BIRTH, March 17, 1920 (Month) (Day) (Year)
--

7-AGE, — yrs., — mos., 21 ds.	If LESS than 1 day, hrs. or min.?
----------------------------------	--

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).	None
--	------

9-BIRTHPLACE, (State or Country),	Baltimore Md -
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10-NAME OF FATHER,	Harry S. Gordon
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11-BIRTHPLACE OF FATHER (State or Country),	Baltimore, Md -
--	-----------------

12-MAIDEN NAME OF MOTHER	Elsie M. Perry
--------------------------	----------------

13-BIRTHPLACE OF MOTHER (State or Country),	Baltimore, Md.
--	----------------

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry S. Gordon

(Address) 729 E. Hoffman St

15-

Filed APR 9 1920 191. ROBERT J. CRAUTH

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 8, 1920 (Month) (Day) (Year)
--

17- I HEREBY CERTIFY, That I attended deceased from 3/19 1920, to April 8 1920, that I saw him alive on April 6 1920, and that death occurred, on the date stated above, at 3-P. m. The CAUSE OF DEATH* was as follows:

Atherosclerosis
(Congestive)
(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)	(Duration) yrs. mos. ds.
-----------------------------	--------------------------

(Signed) John S. French, M. D.	4/9/1920 (Address) 3522 Greenmount Ave.
--------------------------------	---

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds.	In the State yrs. mos. ds.
---------------------------------	----------------------------

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery	DATE OF BURIAL, April 10, 1920
--	-----------------------------------

20-UNDERTAKER George J. Ruth	ADDRESS 735 Hayford Ave.
---------------------------------	-----------------------------

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42081

CERTIFICATE OF DEATH.

81 D42081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 N. Washington ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Nora Minihan

(a) RESIDENCE.

No. 1010 N. Washington ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

55 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

55 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb. 3rd 1846

7 AGE

Years

74

Months

2

Days

4

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

James Minihan

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Ryan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant

Alice J. McManus

(Address)

1010 N. Washington St.

15

Filed

APR 9 - 1920ROBERT F. LAUTHE

Registrar

Barial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 7th 1920

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1920, to April 7, 1920, that I last saw her alive on Apr. 6, 1920, and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:

General arterio-sclerosisCONTRIBUTORY (Secondary) Order of lungs (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Wm J. McInt

M. D.

, 19

(Address) 701 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Cem

DATE OF BURIAL

APR 10 1920

20 UNDERTAKER

Ecc. M. Fink & Son,

ADDRESS

811 N. U. St.

Funeral Directors & Embalmers.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42082

D42082

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *222 N. Ellwood Ave.* ST.; *6* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *222 N. Ellwood Ave.* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

Single

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

April 25, 1894
(Month) (Day) (Year)

7-AGE,

25 yrs. 11 mos. 14 ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Housework at home

9-BIRTHPLACE,

(State or Country),

Baltimore City

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

APR 9 - 1920

ROBERT A. LAUTER

Filed.....

191. Burial Permitted.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 7th, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 5* 191*9*, to *April 7* 1920, that I saw h*er* alive on *April 6* 1920, and that death occurred, on the date stated above, at *8:10* m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis(Duration)..... yrs. *3* mos. *2* ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed).....

April 8, 1920 (Address) *100 S. Potomac Park*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn Cem.

DATE OF BURIAL,

April 10, 1920

20-UNDERTAKER

Lily and Ziehl

ADDRESS

403 S. Wolfe St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42083

CERTIFICATE OF DEATH.

28-010
D42083

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1766 Keyes

ST. 8

WARD)

2-FULL NAME James Joseph Williams

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 1766 Keyes

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

colored

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary Williams

6 DATE OF BIRTH (month, day, and year)

- 1889

7 AGE

Years

Months

Days

If LESS than

1 day. hrs.

or min.

31

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

John Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country)

MD

12 MAIDEN NAME OF MOTHER

Annie Perkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MD

14

Informant

(Address)

Annie Perkins

1766 Keyes St.

15

APR 9 - 1920

ROBERT E. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-6

1920

17

I HEREBY CERTIFY, That I attended deceased from

February 2, 1920, to April 6, 1920.

that I last saw him alive on April 6, 1920.

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary TB.

CONTRIBUTORY (Secondary)

(duration)

yrs.

2

mos.

ds.

(duration)

yrs.

1

mos.

ds.

15 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Shepherd M. D.

19 (Address)

1227 Columbia St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

John A. Owens

537 N. E. St.

CAUSE OF DEATH IN PLAIN LANGUAGE. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42084

CERTIFICATE OF DEATH.

64
REGISTERED NO. C

D42084

PLACE OF DEATH

CITY OF BALTIMORE (No. Pier #2 Locust Point. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin B. Porter Jr.(Residence in Baltimore: No. 505 Pennsylvania Ave. St.; yrs. 53 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Divorced
(Write the word.)6-DATE OF BIRTH, August 6th, 1866., /
(Month) (Day) (Year)7-AGE, 53 yrs. 8 mos. 1 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Clerk. P. & O. R. R. Co.
(b) General nature of industry, business, or establishment in which employed (or employer) RR9-BIRTHPLACE, (State or Country), Baltimore Md.10-NAME OF FATHER, Benjamin B. Porter Sr.11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.12-MAIDEN NAME OF MOTHER Virginia Reid.13-BIRTHPLACE OF MOTHER (State or Country), Norfolk, Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Lee Porter, (brother)(Address) 1308 McCulloh St.

15 APR 9 - 1920

Filed..... 191... ROBERT E. KRAUTER

Social Public Health Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 7th, 1920., 191...
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry and that said deceased came to his death
(Inquest, au- topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.
(Duration) yrs. mos. ds.CONTRIBUTORY (Secondary) St. M. Remhard(Signed) St. M. Remhard D. (Coroner)
April 8, 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Greenmount DATE OF BURIAL, April 10, 192020-UNDERTAKER Henry W. Jenkins and Sons Co ADDRESS McCulloh & Orchard

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42085

CERTIFICATE OF DEATH.

29 D42085
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1323 W. Baltimore St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1323 W. Baltimore St. St.; 45 yrs., 11 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)6-DATE OF BIRTH, April 25, 1874
(Month) (Day) (Year)7-AGE, 45 yrs., 11 mos., 12 ds.
If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, At Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, Charles A. Masterman

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna K. Sevenskott

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis A. Masterman

(Address) 1323 W. Baltimore St.

15-

APR 9 - 1920
Filed

ROBERT E. KAUFER

Baptist Church Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 7, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 6, 1920, to April 7, 1920, that I saw him alive on April 7, 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)(Duration).....yrs.....mos.....ds.
(Signed) Edna and Will Deville M. D.
April 9, 1920 (Address) 2432 1/2 Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Cathedral Cem April 10, 1920

20-UNDERTAKER

ADDRESS 250 N.

Wm. J. Hartwell Fulton Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

42086

CERTIFICATE OF DEATH.

D42086

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *807 Vine* ST.; *18* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Wm Curry*(Residence in Baltimore: No. *807 Vine* St. *18* yrs., *4* mos., *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*C*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Mar*

6-DATE OF BIRTH,

March

(Month)

15

(Day)

1873

(Year)

7-AGE,

47

yrs.

2 mos.*21* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... *Labr*
(b) General nature of industry, business, or establishment in which employed (or employer)...9-BIRTHPLACE, (State or Country), *md*10-NAME OF FATHER, *Wm Curry*11-BIRTHPLACE OF FATHER (State or Country), *md*12-MAIDEN NAME OF MOTHER, *Jane Crumble*13-BIRTHPLACE OF MOTHER (State or Country), *md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Francis Guffen*(Address) *807 Vine St*

15-

Filed

APR 9 - 1920

ROBERT E. KRAUTER

BUTLER HALL Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 6 191*2*, to *April 6* 191*2*,that I saw h... alive on *April 6* 191*2*,and that death occurred, on the date stated above, at *4 P.* m.

The CAUSE OF DEATH* was as follows:

*Coronary**Arteriosclerosis**(Duration) ... yrs. ... mos. ... ds.*

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed)

M. D.

1912 (Address) *739 N. E. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn Cem.

DATE OF BURIAL,

Apr. 9, 1920

20-UNDERTAKER

Clement Hall

ADDRESS

*1037 Myrtle Ave**per 605 W. Mulberry Sts.*

important. See instructions on back of certificate.

D42087

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42087

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1747 N. Gay ST.; 8 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1747 N. Gay St.; yrs., mos. 2 1/2 ds.)Dolores Gardner

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

April 6, 1920
(Month) (Day) (Year)

7-AGE,

yrs. mos. 2 1/2 ds.If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Infant9-BIRTHPLACE,
(State or Country).Baltimore Md

10-NAME OF FATHER,

Wm Gardner11-BIRTHPLACE OF FATHER
(State or Country).Baltimore Md

12-MAIDEN NAME OF MOTHER

Jeanette Hartman13-BIRTHPLACE OF MOTHER
(State or Country).Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Hartman(Address) 1747 N. Gay St.

15-

Filed APR 9 - 1920

101

ROBERT H. KRAUTER

Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 9, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 6, 1920, to April 9, 1920, that I saw her alive on April 8, 1920, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency(Duration) yrs. mos. 2 1/2 ds.CONTRIBUTORY...Cardiac Insufficiency
(Secondary)(Duration) yrs. mos. 2 1/2 ds.(Signed) R. P. Camman M. D.April 9, 1920. (Address) 1707 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 12th WARD)

REGISTERED NO. 36✓ 142088

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE.

77 Mrs. Breun 523 McCulloch St. Baltimore Md.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

male

colored

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

APR 9 1920

ROBERT F. REATTEE

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-8 1920

17

I HEREBY CERTIFY, That I attended deceased from

week 23, 1920, to April 8, 1920.

that I last saw him alive on April 5, 1920.

and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42089

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2213 1st Holly ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Monticello Hall(Residence in Baltimore: No. 2213 1st Holly St.; 63 yrs., 6 mos., 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male4-COLOR OR RACE, white5-SINGLE, MARRIED, married, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, September 21, 1856

(Month)

(Day)

(Year)

7-AGE, 63 yrs., 6 mos., 18 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Credit man 686(b) General nature of industry, business, or establishment in which employed (or employer). Crown Cork & Seal Co.9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George Hall11-BIRTHPLACE OF FATHER (State or Country), Ind.12-MAIDEN NAME OF MOTHER unknown13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Monticello Hall Jr.(Address) 1268 E. North ave.

15-

Filed

APR 9 - 1920

ROBERT A. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 8, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from April 5, 1920, to April 8, 1920,that I saw him alive on April 8, 1920,and that death occurred, on the date stated above, at 10:35 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia(Duration) 18 hrs yrs. mos. ds.CONTRIBUTORY (Secondary) Pleurisy(Duration) 3 yrs. mos. ds.(Signed) Chester Kiland M. D.Apr 9, 1920 (Address) 2532 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London ParkDATE OF BURIAL, Apr 10, 192020-UNDERTAKER, Graham, J. WalkerADDRESS, 723 W. of

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42090

CERTIFICATE OF DEATH.

28 ✓
D42090
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4014 Park Hts Ave ST.; 15 WARD)2-FULL NAME Charles L. Pate Jr.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 4014 Park Hts Ave St.; Life yrs. 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Aug 10, 1898
(Month) (Day) (Year)

7-AGE,

21 yrs. 7 mos. 28 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Bank clerkMer. & Merc Bank

9-BIRTHPLACE,

(State or Country),

city

10-NAME OF FATHER,

Rev. Chas. L. Pate

11-BIRTHPLACE OF FATHER (State or Country),

Balto. Md.

12-MAIDEN NAME OF MOTHER

Mattie N. McKenzie

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Rev Chas. L. Pate

(Address)

4014 Park Hts Ave

15-

Filed

APR 9 - 1920

ROBERT B. LEAUTE

BUTLER PUBLISHING CO.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 7, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Oct 19, 1919, to April 7, 1920;that I saw him alive on April 7, 1920;and that death occurred, on the date stated above, at 9:45 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary(Duration) 6 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

Endocarditis(Duration) 1 yrs. 0 mos. 0 ds.(Signed) Geob. Shannon M. D.Apr. 7, 1920 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Arund Ridge

DATE OF BURIAL

Apr 10, 1920

20-UNDERTAKER

Wm J. Tucker & Son

ADDRESS

NY Pa

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42092

D42092

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 Oakmont av ST.; 27 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 218 Oakmont av St.; 64 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

white5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Married

6-DATE OF BIRTH,

Jan 28, 1856
(Month) (Day) (Year)

7-AGE,

64 yrs., 2 mos., 11 ds.If LESS than 1 day,
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....Car Builder9-BIRTHPLACE,
(State or Country),Md.10-NAME OF
FATHER,Shadrick Kemp11-BIRTHPLACE
OF FATHER
(State or Country),Md12-MAIDEN NAME
OF MOTHEREmma Cruik13-BIRTHPLACE
OF MOTHER
(State or Country),Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Hattie M. Kemp
(Address) 218 Oakmont av

15-

APR 9 - 1920 Robert P. Harrison,
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 8, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
April 7 1920, to April 8 1920,
that I saw him alive on April 8, 1920,
and that death occurred, on the date stated above, at 3:00 p.m.
The CAUSE OF DEATH* was as follows:Lobar Pneumonia
(Duration) about 10 ds.CONTRIBUTORY
(Secondary)(Duration) 7 yrs., mos., ds.
(Signed) G. H. Beckler M. D.
Much... 1920 (Address) 126 W. Baltimore*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Louisa Park Cem April 10, 1920

20-UNDERTAKER

ADDRESS

Chas E. Franck 802 Madison
av126 Bedford

D42093

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42093

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25 N. State ST.; 6 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence C. Connor(Residence in Baltimore: No. 25 N. State St.; Life yrs. 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE W 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH, Aug 8, 1876
(Month) (Day) (Year)7-AGE, 45 yrs. 8 mos. 0 ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 039-BIRTHPLACE, (State or Country), Balto10-NAME OF FATHER, Conrad Albacher11-BIRTHPLACE OF FATHER (State or Country), md.12-MAIDEN NAME OF MOTHER Susan B. Powell13-BIRTHPLACE OF MOTHER (State or Country), md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Connor(Address) 25 N. State St.

15- Robert P. Harrison,

Filed 1920, 191. Burial Permit C

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Apr 6, 1920
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from Jan 1, 1920, to Apr 6, 1920, that I saw him alive on April 6, 1920, and that death occurred, on the date stated above, at 03 m. The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration)....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)(Duration)....yrs.....mos.....ds.
(Signed) Wm. J. G. G. G. M. D.
477, 1st C (Address) 38 E Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.....mos.....ds. In the State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL Apr 10, 192020-UNDERTAKER J. A. Moran ADDRESS 3000 E. Balt.

D42091

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mount Hope Reformat*ST.: *28th* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Richard C. Grogan*(Residence in Baltimore: No. *Mount Hope Reformat*St.: *10* yrs., *0* mos., *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

May *0*, *1846*
(Month) (Day) (Year)

7-AGE,

74 yrs., *0* mos., *0* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

R.C. Priest
*Religious work.*9-BIRTHPLACE,
(State or Country),*Ireland*

PARENTS.

10-NAME OF FATHER,

*Michael Grogan*11-BIRTHPLACE OF FATHER
(State or Country),*Ireland*

12-MAIDEN NAME OF MOTHER

*Annie Lee*13-BIRTHPLACE OF MOTHER
(State or Country),*Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Records of Mount Hope Reformat*(Address) *Mount Hope Reformat*

15-

*Robert P. Harrison,*Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 2, *1910*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 20 1910, to *Apr 2* 1910,that I saw him alive on *Apr 2* 1910,and that death occurred, on the date stated above, at *11:45 P* m.

The CAUSE OF DEATH* was as follows:

*Cerebral Hemorrhage**abs.* (Duration).....yrs.....mos.....ds.CONTRIBUTORY *Chlor. Myelomalacia*
(Secondary)(Duration) *10* yrs. *0* mos. *0* ds.(Signed) *Frank J. F. Cameron* M. D......, 191... (Address) *Mount Hope Reformat*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *10* yrs. *0* mos. *0* ds. In the *10* yrs. *0* mos. *0* ds.Where was disease contracted, *Meriden Conn*
if not at place of death?Former or usual residence *Meriden Conn*

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

New Cathedral Cemetery *April 10, 1910*20-UNDERTAKER
STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)ADDRESS
108 W NORTH AVE

important. See instructions on back of certificate.

APR 9 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42095

D42095

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1541 Argyle Ave* ST. *14* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Richard B. Blake*(Residence in Baltimore: No. *1541 Argyle Ave* St. *40* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *Col*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)6-DATE OF BIRTH *June 17, 1866*

(Month)

(Day)

(Year)

7-AGE *53* yrs. *9* mos. *21* ds.

If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Poster of*9-BIRTHPLACE, (State or Country), *Balto md*10-NAME OF FATHER, *Richard B. Blake*11-BIRTHPLACE OF FATHER (State or Country), *md*12-MAIDEN NAME OF MOTHER *Julia Harrod*13-BIRTHPLACE OF MOTHER (State or Country), *md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harriet B. Blake*(Address) *1541 Argyle Ave*

15-

Robert F. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *April - 7 - 1920*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from *Mar 3* 19*20* to *Apr 6* 19*20*, that I saw him alive on *Apr 6* 19*20* and that death occurred, on the date stated above, at *119* m. The CAUSE OF DEATH* was as follows:*Acute Endocarditis*(Duration) *1* mos. *14* ds.CONTRIBUTORY (Secondary) *Arteriosclerosis*(Duration) *1* mos. *14* ds.(Signed) *S. B. Hughes*Address) *1413 2nd Hill*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDE, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *The Auburn*DATE OF BURIAL, *April 11, 1920*20-UNDERTAKER *Wm. W. Chaswell*ADDRESS *1400 Maple*

important. See instructions on back of certificate

APR 9 - 1920

D42096

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D42096

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 Taylor ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John H. Biltz (Bell)

(a) RESIDENCE. No.

15 Taylor

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Don't know name.

6 DATE OF BIRTH (month, day, and year)

Sept 28 1894

7 AGE

Years,

Months

Days

If LESS than

1 day, hrs.

or min.

28

6

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Paper Ruler.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Henry Biltz (Bell)

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Annie M. Kindein

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md.

14

Informant (Address)

Annie M. Biltz (Bell) 15 Taylor Street

15

led

Robert F. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 8 - 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 7th 1920, to April 8th 1920

that I last saw him live on April 7th 1920

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration)

1 yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

7 ds.

18 Where was disease contracted if not at place of death?

L. Harrison

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Physiologist examination

(Signed)

Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Josephs - Belair Road

April 13 1920

20 UNDERTAKER

ADDRESS

William Cook

502 E. North Ave.

CAUSE OF DEATH is very important. See instructions on back of certificates.

APR 9 - 1920

D42097

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42097

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2232 N. Calvert ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

George J. Thompson

(a) RESIDENCE. No.

2232 N. Calvert ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

6 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Don't know

6 DATE OF BIRTH (month, day, and year)

Don't know

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

abt 49

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Don't know

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Alex M. Rutherford
210 E. Lexington St

15

Filed

Robert P. Harrison,

Registrar

APR 9 - 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 7 - 1920

17

I HEREBY CERTIFY, That I attended deceased from January 27, 1919, to April 6, 1920, that I last saw him alive on April 6, 1920, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.about 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Pathology(Signed) Howard E. Gooden, M. D.
48, 1920 Address) 530 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

 Druid Ridge

DATE OF BURIAL

April 10 - 1920

20 UNDERTAKER

William Cook

ADDRESS

502 E. NorthCAUSE OF DEATH
TION is very important. See instructions on back of certificate.

D42098

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42098

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407-7. Exeter

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Corretta Maggio

(a) RESIDENCE. No.

407-7. Exeter

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S., if of foreign birth? 22 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 ~~Single, Married, Widowed,~~~~or Divorced (write the word)~~

Widowed

5a If married, widowed, or divorced

(WIFE of

Vincenzo Maggio

6 DATE OF BIRTH (month, day, and year)

1/3/1870

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

50

3

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town)
(State or country)

Italy

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Italy

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Italy

14

Informant
(Address)Mrs. John D. Stephens
407-7. Exeter St.

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1920

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 15, 1919, to April 7, 1920,

that I last saw him alive on April 7, 1920,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Progressive Muscular Atrophy

(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Pneumonia - Bronchial

(duration) yrs. mos. 2 ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Margaret C. Gillis, M. D.

Apr. 9, 1920 (Address) 924 W. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Vincent Cemetery

4/11/20

20 UNDERTAKER

ADDRESS

Geo. J. Puth 1735 Hayfield

TION is very important. See instructions on back of certificates.

APR 9 - 1920

D42099

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42099

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1043 Roland Heights St. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1043 Roland Heights St. 36 yrs., 36 mos., 36 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

June 30th, 1844
(Month) (Day) (Year)

7-AGE,

75 yrs., 9 mos., 8 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework
Home9-BIRTHPLACE,
(State or Country),

Carroll Co. Md.

10-NAME OF FATHER,

James Price

11-BIRTHPLACE OF FATHER
(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

C. M. L. Cook

13-BIRTHPLACE OF MOTHER
(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Roberta Metcalf
1043 Roland Heights St.

(Address)

15-

Robert P. Harrison,
191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 8, 1910
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 11, 1910, to April 8, 1910,that I saw her alive on April 5, 1910,and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Death Dilatation of Heart
following exertion
(Duration) 30 minutes yrs. mos. ds.CONTRIBUTORY Arteriosclerosis
(Secondary)(Duration) 1 yrs. 2 mos. 2 ds.(Signed) Albert J. Metcalf M. D.April 8, 1910 (Address) 3547 Roland St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 36 yrs. 36 mos. 36 ds. In the State 36 yrs. 36 mos. 36 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Landon Park

DATE OF BURIAL

April 15, 1910

20-UNDERTAKER

Bellamy & Co.

ADDRESS

123 W. Lafayette Ave

important. See instructions on back of certificate.

D42100

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *South Balto Gen Hospital*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2007 E. Preston*)St.; *10* yrs., *10* mos., *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Married*

6-DATE OF BIRTH,

April 1, 1920
(Month) (Day) (Year)

7-AGE,

37 yrs. *10* mos. *10* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Merchant*
*Shoe Store*9-BIRTHPLACE,
(State or Country),*Horný K. or Li Bohemia*

10-NAME OF FATHER,

*John Salivoda*11-BIRTHPLACE OF FATHER
(State or Country),*Bohemia*

12-MAIDEN NAME OF MOTHER

*Barbara Savils*13-BIRTHPLACE OF MOTHER
(State or Country),*Bohemia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert P. Harrison*(Address) *2007 E. Preston St.*

15-

Robert P. Harrison,

APR 10 1920

191.....

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 7, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*April 6, 1920, to April 7, 1920,*that I saw him alive on *April 7th, 1920,*and that death occurred, on the date stated above, at *8:30* m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis.....(Duration).....*10* yrs. *10* mos. *10* ds.CONTRIBUTORY
(Secondary).....(Duration).....*10* yrs. *10* mos. *10* ds.(Signed) *Emil Novak* M. D.*Apr 8, 1920* (Address) *26 E. Preston St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *2* mos. *2* ds. In the State yrs. *10* mos. *10* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Cross

DATE OF BURIAL,

Apr 10, 1920

20-UNDERTAKER

Emil Novak

ADDRESS

26 E. Preston St.

DR. EMIL NOVAK
26 EAST PRESTON STREET
BALTIMORE, MD.

2

BY

April 20, 1920.

This is to certify that the following correction
is to be made in the death certificate of Joseph Kalivoda,
filed with your Department on April 8, 1920:

Duration of disease to be changed from "ten years"
to "several months."

Signed Emil Novak

I hereby certify that Emil Novack^{sub} personally appeared
before me at Baltimore Md and made oath that the above statement
is true and correct, this 24th day of April 1920.

.....
Notary Public.



D42101

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42101

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 N. Charles ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(Mr. Frank (Oscar) Hinds.)

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds.

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 8, 1865

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

55

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salmon

(b) General nature of industry, business, or establishment in which employed (or employer)

Tailor

(c) Name of employer

Kemp & Amiger

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

William S. Hinds

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Laford

12 MAIDEN NAME OF MOTHER

Emily M. Barron

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Harry J. Hinds 110 N. Charles St.

15

Illegible

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-9-20

1920

17

HEREBY CERTIFY, That I attended deceased from

Apr. 2nd, 1920, to April 9th, 1920.that I last saw her alive on April 9th, 1920.

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis,
Chronic Interstitial
Nephritis.

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 17 ds.

18 Where was disease contracted?

If not at place of death?

Did an operation precede death?

yes Date of Apr. 3rd

Was there an autopsy?

What test confirmed diagnosis? Physical Examination

(Signed) Arthur Chas. Meyer, M. D.

4/8, 1920 (Address) Md. Gen'l. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Houlton Park. April 10, 1920

20 UNDERTAKER

ADDRESS

George J. Smith, 110 N. Charles St.

APR 10 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42102

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. _____ ST. _____ WARD _____)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1S.)

2-FULL NAME

(Residence in Baltimore: No. _____ St. _____ yrs., _____ mos., _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Varrison,

191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

4/11/20 191, to 4/19/20 191,

that I saw him alive on 4/11/20 191,

and that death occurred, on the date stated above, at 2:00 p.m.

The CAUSE OF DEATH* was as follows:

Dementia, complicated
by pneumonia

(Duration).....yrs....1....mos....9....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs....mos....ds.

(Signed).....M. D.

4/8/20, 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs....mos....ds. In the State.....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

APR 10 1920

D42103

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42103

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4204 Greenwood ST.; 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louise Bell(a) RESIDENCE. NO. 4204 Greenwood ST.;

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 3mos. 20

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 14 197 AGE Years Months Days If LESS than 1 day, hrs. or min. 3 20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md10 NAME OF FATHER Stanley M Bell11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio Cincinnati12 MAIDEN NAME OF MOTHER Freda Snyder13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md14 Informant Stanley M Bell(Address) 4204 GreenwoodRobert F. Harrison,

Registrar

APR 10 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-9 192017 I HEREBY CERTIFY, That I attended deceased from April 9, 1920, to April 9, 1920, that I last saw her alive on April 9, 1920, and that death occurred, on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted at home

If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) H. C. Weiss, M. D.4-9, 1920 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Landon Park CemeteryApril 10 1920

20 UNDERTAKER

ADDRESS

W M Routson2238 N. North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42104

D42104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 N. Fulton Ave ST.; 16 WARD)

REGISTERED NO. C

2-FULL NAME

Ellen Catherine Jones Anderson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1010 N. Fulton Ave St.; 9 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH,

Feb. 24, 1892
(Month) (Day) (Year)

7-AGE,

78 yrs., 1 mos., 17 ds.If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).retired!

9-BIRTHPLACE, (State or Country),

Md.

10-NAME OF FATHER,

Barton Garrett

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Blanche Anderson

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Anderson(Address) 1010 N. Fulton Ave

15-

APR 10 1920

Robert P. Harrison, Dee Hollows Davidson

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Feb 1919, to Apr 9, 1920,that I saw him alive on Apr 9, 1920,and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Ch. Myocarditis +arterio-sclerosis (Duration) 5 yrs., mos., ds.

CONTRIBUTORY (Secondary)

 (Duration) yrs., mos., ds.(Signed) H. R. Little M. D.Apr 10, 1920. (Address) 617 N. Carroll St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL.

Dee Hollows Davidson April 17, 1920

20-UNDERTAKER

ADDRESS

John O. Mitchell 1201 Fayette St.

11/29/20-3

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ D42105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

plus Hopkins Hospital

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Agnes Bunge

(a) RESIDENCE. NO.

5-18 TC Bradford St. Baltimore Md.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

+

6 DATE OF BIRTH (month, day, and year)

Feb 5, 1917

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

2

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Child

9 BIRTHPLACE (city or town) (State or country)

Baltimore

Md.

10 NAME OF FATHER

Philip Bunge

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Frances Valente

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

J. H. Bunge

15

Filed

APR 10 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 8

1920

17

I HEREBY CERTIFY, That I attended deceased from

April 1

1920, to

April 8

1920,

that I last saw him alive on

Apr 8

1920,

and that death occurred, on the date stated above, at

6

P m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

military tuberculosis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Patient's home

Did an operation precede death?

no

Date of

Was there an autopsy?

yes

What test confirmed diagnosis?

Clinical + autopsy

(Signed)

J. H. Bunge

M. D.

, 19

(Address)

J. H. Bunge

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer

DATE OF BURIAL

April 10 1920

20 UNDERTAKER

Wm. Cook

ADDRESS

602 E. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42106

D42106

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1002 Sharp* ST.: *23* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *1002 Sharp* ST., *22* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *5* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Henry Teaters*6 DATE OF BIRTH (month, day, and year) *Unknown 1994*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *36*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Carpenter*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Dakota* (State or country)10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) *Unknown* (State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Unknown* (State or country)

14

Informant (Address) *Coran Teaters*
1002 Sharp St

15

Robert F. Harrison, Registrar

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 8*, 19*20*17 I HEREBY CERTIFY, That I attended deceased from *April 2*, 19*20*, to *April 8*, 19*20*, that I last saw him alive on *April 8*, 19*20*, and that death occurred, on the date stated above, at *4 P.* m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(duration) yrs. mos. *9* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

J. M. Delirett, M. D.Address *621 Columbia Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Irwan Va**April 13*

20 UNDERTAKER

ADDRESS

Mrs J. E. Evans

TION is very important. See instructions on back of certificates.

APR 10 1920

D42107

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓ D42107
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 McCullough

ST.: 11

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1022 McCullough

St.; 2 yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

Caucasian

5-SINGLE,

MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

July 26, 1917.
(Month) (Day) (Year)

7-AGE,

2 yrs., 8 mos., 14 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

North Carolina

10-NAME OF FATHER,

John Patterson

11-BIRTHPLACE OF FATHER (State or Country),

North Carolina

12-MAIDEN NAME OF MOTHER

Edna Daniels

13-BIRTHPLACE OF MOTHER (State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel E. Harrison

(Address) 916 Pennsylvania Ave.

15-

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 9, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 8, 1920, to April 9, 1920,

that I saw him alive on April 8, 1920,

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) Unknown ds.

CONTRIBUTORY (Secondary)

(Duration) Unknown ds.

(Signed) M. D. Harrison

April 9, 1920. (Address) 2439 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 10 mos. ds. In the 2 yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 1022 1/2 Midway Ave.

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn Cem.

DATE OF BURIAL,

April 10, 1920

20-UNDERTAKER

Daniel E. Harrison

ADDRESS

916 Pennsylvania Ave.

APR 10 1920

D42108

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42108

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *79* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mr. James Calloway

(a) RESIDENCE. NO.

720 Forsyth St. Macon Georgia

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mrs. Anne Furlow Calloway

6 DATE OF BIRTH (month, day, and year)

Jan 12 1847

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*73**2**10*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Newspaper Man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Georgia

10 NAME OF FATHER

Marcel P Calloway

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Georgia

12 MAIDEN NAME OF MOTHER

Mary Irvine

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Georgia

14

Informant (Address)

J. H. H. Beards

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-10 1920

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 8, 1920, to April 10, 1920.*that I last saw him alive on *April 10, 1920.*and that death occurred, on the date stated above, at *3:20 a m.*

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency(duration) *1 yrs 6 mos.* ds.

CONTRIBUTORY (Secondary)

Artero. Sclerosis(duration) *3 yrs.* mos. ds.

18 Where was disease contracted if not at place of death?

*Georgia*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *William S. Tillet*, M. D.4/14 1920 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Macon Georgia**April 10 1920*

20 UNDERTAKER

ADDRESS

*Henry J. Perkins & Sons**Macon Georgia*

TION is very important. See instructions on back of certificate.

APR 10 1920

D42109

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42109

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *414 Euseb St* ST. *27* WARD)

REGISTERED No. C

2-FULL NAME

Chas S. Marks

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *414 Euseb St*

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*Colored*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Married*

6-DATE OF BIRTH,

Not known 1868
(Month) (Day) (Year)

7-AGE,

52 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Labourer*9-BIRTHPLACE,
(State or Country),*Ind*

10-NAME OF FATHER,

*Chas S Marks*11-BIRTHPLACE OF FATHER
(State or Country),*Ind*

12-MAIDEN NAME OF MOTHER

*Martha A. Smith*13-BIRTHPLACE OF MOTHER
(State or Country),*Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Filed

01920

191

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr 9, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* ~~autopsy~~ or inquiry.)thereon and from the evidence obtained by said *inquest* ~~autopsy~~ *inquest*and that said deceased came to *his* death ~~on the day stated above.~~
The CAUSE OF DEATH* was as follows:*Cerebral apoplexy*(Duration) yrs. mos. ds. *1 hour*CONTRIBUTORY
(Secondary)*Not known*

(Signed)

R. P. Harrison M. D.
(Coroner.)4-10-1912 (Address) *117 W. ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

Not known *April 11, 1920*

20-UNDERTAKER

ADDRESS

Mrs. Scott Hooper *1506 Euseb St*

important. See instructions on back of certificate.

D42110

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42110

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *116 W. Twenty seventh* ST.: *12* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Wm Dorcie Rock

(a) RESIDENCE. No.

116 W. Twenty seventh

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 24th 1919

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*8**14*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore
Maryland*

10 NAME OF FATHER

*Everett D. Rock*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Hammerock
Virginia*

12 MAIDEN NAME OF MOTHER

*Blanche R. Ball*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Baltimore
Maryland*

14

Informant
(Address)*Everett D. Rock
116 W. Twenty seventh St.*

15

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 5 1920

17

I HEREBY CERTIFY, That I attended deceased from

*April 4, 1920, to April 8, 1920.*that I last saw him alive on *April 8, 1920.*and that death occurred, on the date stated above, at *2 a. m.*

The CAUSE OF DEATH* was as follows:

Convulsion

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Corona Protestant Church**April 10 1920*

20 UNDERTAKER

ADDRESS

*Fred. Bushman**Baltimore*

CAUSE OF DEATH IN PLAIN TERMS, so that it may be understood by the jury, should be written on back of certificate. See instructions on back of certificates.

APR 10 1920

-239

PLACE OF DEATH

42111

County

Village or City

Balto

(No.

410 Carroll

St.

Ward)

Registration Dist. No.

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

FULL NAME

Archie Peterson

PERSONAL AND STATISTICAL PARTICULARS

SEX: *Male* 4 COLOR OR RACE: *Col* 5 SINGLE MARRIED, WIDOWED OR DIVORCED (Write the word) *Married*

DATE OF BIRTH

Unknown, 1872
(Month) (Day) (Year)

AGE

48 yrs. mos. ds. if LESS than 1 day, hrs. OR min. ?

OCCUPATION

(a) Trade, profession, or particular kind of work

Cannery

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (State or country)

H. R. A. & Co

PARENTS

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robert P. Harrison

(Address)

1021 Carroll St

Robert P. Harrison,

PR1 01920

191

Burial Permit Clerk

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

42111

45

(Brooklyn)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 8, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

Apr 8, 1920, to *Apr 8*, 1920,

that I last saw him alive on *Apr 8*, 1920,

and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Contributory

Secondary

Exhaustion (Duration) yrs. 3 mos. ds.

(Signed)

Chas. J. Brooke

Apr 9, 1920 (Address) *#1. 3rd Bldg*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*St. Hubert**Apr 11*, 1920

20 UNDERTAKER

ADDRESS

*Sam. H. Chase**1400 M. St.*

D42112

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42112

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1429 John

ST.; 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Eleanor Sellman

(Residence in Baltimore: No. 1429 John

St.; 15 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
 4-COLOR OR RACE, W.
 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) I
 6-DATE OF BIRTH, December 27, 1841
 (Month) (Day) (Year)

7-AGE, 78 yrs. 3 mos. 13 ds.
 If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. Lady
 (b) General nature of industry, business, or establishment in which employed (or employer). at Home

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, James C. Sellman

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Mary Fowarden

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry V. B. Sellman

(Address) 1429 John St.

15-

Robert F. Harrison,

APR 10 1920 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 10, 1920
 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from April 5, 1920, to April 10, 1920, that I saw her alive on April 9, 1920, and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus,

(Duration) May yrs. mos. ds.

CONTRIBUTORY (Secondary) Central apoplexy

(Signed) Charles M. D.
 Apr 10, 1920. (Address) 1327 Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount

DATE OF BURIAL, Apr. 12, 1920

20-UNDERTAKER, Henry W. Jenkins
 ADDRESS, 440 N. E. St.

D42113

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1214 Emsaw Place* ST.: *11* WARD)

2-FULL NAME

Jefferson M. Lewis

(a) RESIDENCE. NO.

1214 Emsaw Pl. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *18* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed.

~~Divorced~~ (write the word)*Married*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Eva Malcolm Lewis*

6 DATE OF BIRTH (month, day, and year)

Dec. 5-1835

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*84**4**14*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Retired*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Newberry
S.C.*

10 NAME OF FATHER

*John Lewis*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*don't
know*

12 MAIDEN NAME OF MOTHER

*Hannie Workman*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*don't
know*

14

Informant
(Address)*B. Palmer Lewis**Robert P. Harrison,*

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*4-9*19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

Jan 2, 19 *20*, to *Apr. 9*, 19 *20*.that I last saw him alive on *Apr. 9*, 19 *20*.and that death occurred, on the date stated above, at *12.20* m.

The CAUSE OF DEATH* was as follows:

Myocarditis.(duration) *3* yrs. *6* mos. *2* ds.CONTRIBUTORY
(Secondary)*Acute dilatation of
Heart* (duration) yrs. *10* min.

18 Where was disease contracted

If not at place of death?

Do not know

Did an operation precede death?

No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Ernest J. Smith* M. D., 19 (Address) *#17 1/2 Biddle St.**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Talledaga, Alabama.**4-11* 19 *20*

20 UNDERTAKER

H.W. Jenkins & Sons Co

ADDRESS

Balto-

TION is very important. See instructions on back of certificate.

APR 10 1920

042114 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 695 Greenwillow St.

ST.: 17 WARD)

REGISTERED NO. C

2-FULL NAME Lucinda Brown

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 605 Greenwillow St.

St.: 2 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female
4-COLOR OR RACE, Colored
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, 1
(Month) (Day) (Year)

7-AGE, 61 yrs., mos., da.
If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Virginia

10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (State or Country), Unknown
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Simmons

(Address) 695 Greenwillow St.

15-APR 11 1920
FILED CORREY & LEAUTE
Boris Fern

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 8 1920, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry find that said deceased came to death
(Inquest, au- topsy or inquiry.) on the day stated above.
The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.
(Signed) J. E. Smith M. D.
(Coroner.)
Ap. 9 1920 (Address) 40 Siglist

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS,

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42115

CERTIFICATE OF DEATH.

109✓ D42115
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5106 Centre St. Govans St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 5106 Centre St. Govans St.; 60 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Married

6-DATE OF BIRTH,

December 25, 1842
(Month) (Day) (Year)

7-AGE,

77 yrs., 3 mos., 13 ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Custom Shoemaker

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

John Schleifer

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Regina Deierlein

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theophila Schleifer(Address) 5106 Centre St. Govans Md

15-

Filed

APR 11 1920

ROBERT B. ELLAUER

BIRTH REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr 7, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr 1, 1920, to Apr 7, 1920,that I saw him alive on Apr 7, 1920,and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

In formation of age
complicated with
intestinal obstruction

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) E. H. Deaneau M. D.Apr 9, 1920 (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St Mary's Church

DATE OF BURIAL,

April 10, 1920

20-UNDERTAKER

C. A. Wiedefeld Jr

ADDRESS

Greenmount Ave

D42116

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D42116

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 N. Bond ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Sanders(a) RESIDENCE. No. 511 N. Bond ST.: 7 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 1 mos. 1 ds.How long in U. S., if of foreign birth? 5 yrs. 1 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1

7 AGE

54

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Doctor

(b) General nature of industry, business, or establishment in which employed (or employer)

general

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.10 NAME OF FATHER Hesikiah Sanders

11 BIRTHPLACE OF FATHER (city or town)

Balto.

(State or country)

12 MAIDEN NAME OF MOTHER Mary Watkins

13 BIRTHPLACE OF MOTHER (city or town)

Balto.

(State or country)

14

Informant (Address) Estelle Rogers511 N. Bond St

15

111111111111

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8 1920

17

I HEREBY CERTIFY, That I attended deceased from March 24, 1920, to April 8, 1920, that I last saw him alive on April 8, 1920, and that death occurred, on the date stated above, at 3:55 a m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage, resulting from fall down steps

CONTRIBUTORY (Secondary)

(duration) yrs. 10 mos. 10 ds.(duration) yrs. 2 mos. 10 ds.18 Where was disease contracted if not at place of death? Balto.Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? clinical(Signed) J. M. C. C. C.Address 1520 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Auburn Cemetery April 11 1920

20 UNDERTAKER

ADDRESS

P. B. Gross 1405 McElmyer St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42117

CERTIFICATE OF DEATH.

D42117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

18 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

18 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

35

Years

Months

Days

If LESS than I day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filing

APR 11 1920

ROBERT A. REAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

April 3, 1920, to April 9, 1920,

that I last saw him alive on April 9, 1920,

and that death occurred, on the date stated above, at 6:15 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Ryan, M. D.

4/10/20 (Address) 80 N. Kentwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed APR 11 1920

ROBERT A. LAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from March 28, 1920, to April 9, 1920,

that I last saw him alive on April 9, 1920,

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH was as follows:

Erysipelas

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42119

CERTIFICATE OF DEATH.

6-091 D42119
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2827 Rayner Ave ST.: 16 WARD)

2-FULL NAME

Ignatius Perost Alain, Jr.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2827 Rayner Ave. St.: 2 yrs., 3 mos., 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Single

6-DATE OF BIRTH,

Jan 21st, 1918.
(Month) (Day) (Year)

7-AGE,

2 yrs., 2 mos., 20 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Balls Blad. Md.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15

APR 11 1920

ROBERT B. KRAUTER

Filed

191

Baltimore City Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 10th, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr. 6 1920, to Apr. 10th 1920,that I saw him alive on Apr. 10th 1920,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

measles

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) James E. Dickson M. D.Apr. 11th, 1920 (Address) 3055 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

April 12, 1920

20-UNDERTAKER

George J. Smith

ADDRESS

1000 W. 11th St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42120

CERTIFICATE OF DEATH.

45 D42120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2628 N. Charles ST.; 12 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2628 N. Charles St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male white

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

July 18, 1851 (Month) (Day) (Year)

7-AGE,

68 yrs., 8 mos., 20 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

APR 11 1920

ROBERT K. KRAUTER

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 9, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 28, 1920, to April 1920,

that I saw him alive on April 9, 1920,

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Cancer of prostate and bladder

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

April 11, 1920 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park

April 20, 1920

20-UNDERTAKER

ADDRESS

Chas. E. Franck

802 Madison

1340 S. Charles

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42121

CERTIFICATE OF DEATH.

108

D42121

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland Gen'l Hospital* ST. *27* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles Edward Muller

(a) RESIDENCE. NO.

(Usual place of abode)

Lexington Road ST. *27* WARD. (*Resident*)

Length of residence in city or town where death occurred

25 yrs.*?* mos.*?* ds.

How long in U. S., if of foreign birth?

61 yrs.*5* mos.*18* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mattie Matthai Muller

6 DATE OF BIRTH (month, day, and year)

October - 21/1858

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*61**5**18*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Salesman

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

not known Maryland

10 NAME OF FATHER

Henry Muller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balti. Co. Maryland

12 MAIDEN NAME OF MOTHER

Mary C. Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Maryland

14 Informant (Address)

Mrs C. Edw. Muller - (wife) Lexington Road - City

15

Filed

APR 11 1920

ROBERT E. KRAUTER Registrar

Burial Permit 01011

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. - 9th 1920

17

I HEREBY CERTIFY, That I attended deceased from *Apr. 8th 1920* to *Apr. 9th 1920*, that I last saw him alive on *Apr. 9th 1920*, and that death occurred, on the date stated above, at *2:35 P. M.*

The CAUSE OF DEATH* was as follows:

Acute Gangrenous Appendicitis(duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

Cardiac dilatation(duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *Apr. 8th*Was there an autopsy? *no*What test confirmed diagnosis? *operation*(Signed) *M. B. Deakynne* M. D.4-9-1920 (Address) *Maryland General Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Druid Ridge Cemetery**Apr 11/ 1920*

20 UNDERTAKER

STEWART & MOWEN COMPANY

(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

TION is very important. See instructions on back of certificate.

D42123

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1734 Gough

ST.: 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edward Bersaro

(a) RESIDENCE, NO.

1734 Gough

ST.,

WARD,

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

3 1/2

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

October 7 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

6

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Charles Bersaro

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Philadelphia, P. D.

12 MAIDEN NAME OF MOTHER

Lorraine Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Charles Bersaro

1734 Gough

15

APR 11 1920

ROBERT H. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 9 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 7 1920 to April 9 1920.

that I last saw him alive on April 9 1920.

and that death occurred, on the date stated above, at 7:00 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

April 10 1920 (Address) 16 S. B. B. B.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Vincent's Church

April 1920

20 UNDERTAKER

Mundell D. Appel & Son

ADDRESS

378 N. Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42124

CERTIFICATE OF DEATH.

D42124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 West Lexington St. WARD)

2-FULL NAME

Maria Louise Albough

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE, No.

801 W Lexington St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofSelf with Clinton Albough

6 DATE OF BIRTH (month, day, and year)

Jan 1, 1852

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.6839

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore
Maryland

10 NAME OF FATHER

Craighton W. Brant

PARENTS

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

England

12 MAIDEN NAME OF MOTHER

Ketur Rial

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

York Pa

14

Informant
(Address)Self with C. Albough
801 W. Lexington

15

Filed

19

APR 1 1920

ROBERT B. FRATER
Registrar

Social Death Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10 1920

17

HEREBY CERTIFY, That I attended deceased from

Apr 9, 1920, to Apr 10, 1920,that I last saw him alive on Apr 9, 1920,and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy.(duration) yrs. mos. 1/2 ds.CONTRIBUTORY
(Secondary)Arterio-sclerosis(duration) yrs. mos. ? ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? none(Signed) M. Hanna M. D.19 (Address) 113 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn4/10 1920

20 UNDERTAKER

Wm Cook

ADDRESS

15 S. No.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42125

CERTIFICATE OF DEATH.

28 D42125

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #5 Newton Ave. ST.: 27 WARD)2-FULL NAME Hugh Joseph Crowley(a) RESIDENCE. NO. #5 Newton Ave. ST. 27 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
----------------------	---------------------------------	---

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) May 9th 18867 AGE Years 33 Months 11 Days —If LESS than
1 day, hrs. —
or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)10 NAME OF FATHER Hm. Crowley11 BIRTHPLACE OF FATHER (city or town)
(State or country)12 MAIDEN NAME OF MOTHER Anne C. Cunningham13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

APR 11 1920

ROBERT E. KRAUTER

Registrar

Serial Permit 0100

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9th 192017 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1920, to April 9th, 1920.that I last saw him alive on April 7th, 1920.and that death occurred, on the date stated above, at 12:05 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia
TuberculosisAbout (duration) 11 yrs. — mos. — ds.CONTRIBUTORY
(Secondary)

(duration) yrs. — mos. — ds.

18 Where was disease contracted
if not at place of death? 1302 N. Mosher St. Balt.Did an operation precede death? no Date of —Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Charles J. Neill, M. D.19 (Address) 1302 N. Mosher St. Balt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery Apr 12 1920

20 UNDERTAKER

ADDRESS

Come Cook 502 E. North

TION is very important. See INSTRUCTIONS on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42126

CERTIFICATE OF DEATH.

79 REGISTERED NO.

D42126

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1822 E Pratt ST. WARD)

2-FULL NAME

(a) RESIDENCE, NO. 1822 E Pratt ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs.

mos.

ds.

How long in U. S. If of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Marion F. Downer

6 DATE OF BIRTH (month, day, and year)

Apr 4, 1883

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

37

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

Shirley & Muff.

(c) Name of employer

Schmidt & Kriete

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

George Downer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Katherine Knott

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Marion F. Downer 1822 E. Pratt St.

15

APR 11 1920

ROBERT E. TRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 8 1920

17

I HEREBY CERTIFY, That I attended deceased from

Diby 1920 to April 8 1920

that I last saw him alive on April 8 1920

and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? yes

(Signed) Al S. Sage M. D.

19 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer. Apr 12 1920

20 UNDERTAKER

ADDRESS

Cumberood 605 E. North Ave

TION is very important. See instructions on back of certificate.

D42127

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

D42127

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1632 N. Fayette ST.; 19 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1632 N. Fayette

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 54 yrs., 4 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male
 4-COLOR OR RACE. W.
 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married
 6-DATE OF BIRTH. Nov. 13, 1864
 (Month) (Day) (Year)

7-AGE. 54 yrs., 4 mos. 25 ds.
 If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. General
 (b) General nature of industry, business, or establishment in which employed (or employer). Merchandising

9-BIRTHPLACE, (State or Country). Md.

10-NAME OF FATHER. Robert N. Ramsay

11-BIRTHPLACE OF FATHER (State or Country). Pa.

12-MAIDEN NAME OF MOTHER. Margaret Heaps

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Ramsay

(Address) 1632 N. Fayette St.

15-

APR 11 1920

101

ROBERT E. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. April 9, 1920
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1919, to April 9, 1920, that I saw him alive on April 8, 1920, and that death occurred, on the date stated above, at 5:45 m.

The CAUSE OF DEATH* was as follows:
 Carcinoma of the Stomach
 (Duration) 7 yrs., ... mos., ... ds.

CONTRIBUTORY (Secondary) (Duration) ... yrs., ... mos., ... ds.

(Signed) James J. Ashurst, M.D.
 April 9, 1920 (Address) 4012 Park Heights

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Highland Harford Co. Md.

DATE OF BURIAL.

April 12, 1920

20-UNDERTAKER

Harry H. Metzke

ADDRESS

1531 W. Lombard St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42128

CERTIFICATE OF DEATH.

D42128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital*ST. *22* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Sterna Slodovich*(a) RESIDENCE. No. *721 W Pratt St*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *6* yrs.

mos.

ds. How long in U. S., if of foreign birth? *6* yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*George Slodovich*6 DATE OF BIRTH (month, day, and year) *1886*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*34*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Austria*

10 NAME OF FATHER

F. Parkus

PARENTS

11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Austria*

12 MAIDEN NAME OF MOTHER

*Frank*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Austria*

14

Informant
(Address)*University Data
Green - Lombard St.*

15

Filed

*APR 11 1920**ROBERT E. KAUTER*
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 10 1920*

17

I HEREBY CERTIFY, That I attended deceased from
Mar 27, 19*20*; to *Apr 10*, 19*20*.that I last saw him alive on *Apr 9*, 19*20*.and that death occurred, on the date stated above, at *3:05* a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

former residence

Did an operation precede death?

yes Date of *3/30/20*

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed) *C. R. Schuerer*, M. D.*4/10, 1920* (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**April 14 1920*

20 UNDERTAKER

ADDRESS

*Harold H. Hight**1531 1/2 Lombard St.*

TION is very important. See instructions on back of card.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42129

CERTIFICATE OF DEATH.

61 D42129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2534 W. Lombard ST.; 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred N. Reichert(Residence in Baltimore: No. 2534 W. Lombard St.; 14 yrs., 11 mos., 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH, January 28, 1882
(Month) (Day) (Year)7-AGE, 38 yrs., 2 mos., 11 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer) own9-BIRTHPLACE, (State or Country), Hungary10-NAME OF FATHER, Nicholas Reichert11-BIRTHPLACE OF FATHER (State or Country), Unknown12-MAIDEN NAME OF MOTHER Unknown13-BIRTHPLACE OF MOTHER (State or Country), Hungary

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederica Reichert(Address) 2534 W. Lombard St.

15-

Filed APR 11 1920

ROBERT B. LEAUTEUR

Baltimore Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 8, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 8 1920, to April 8 1920, that I saw him alive on April 8 1920, and that death occurred, on the date stated above, at 10:50 m. The CAUSE OF DEATH* was as follows:Meningitis(Duration) yrs. mos. 1 ds.CONTRIBUTORY (Secondary) Rhinitis(Duration) yrs. mos. 3 ds.(Signed) Joseph E. Mace M. D.Apr. 9, 1920 (Address) 1520 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Weston Cemetery DATE OF BURIAL, April 12, 192020-UNDERTAKER Harry H. Nitche ADDRESS 1531 W. Lombard St.

Important. See instructions on back of card.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42130

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *Maple St.*)

WARD)

FULL NAME

(Residence in Baltimore: No. *Garner Station*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *2* yrs., *2* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Bald*

6-DATE OF BIRTH,

December 8, 1916
(Month) (Day) (Year)

7-AGE,

3 yrs., *4* mos., *2* ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Baltimore, N. C.

10-NAME OF FATHER,

George D. Burdette

11-BIRTHPLACE OF FATHER (State or Country),

Laurens, S. C.

12-MAIDEN NAME OF MOTHER

Edith C. Cooper

13-BIRTHPLACE OF MOTHER (State or Country),

Charlotte, N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

APR 11 1920

ROBERT E. KRAUTER

DEPT. OF HEALTH REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 10, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an... (Inquest, autopsy, or inquiry.)

thereof and from the evidence obtained by said... (Inquest, au-

opsy or inquiry.) and that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns, while playing with fire
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Signed)

4-10-1920 (Address) *48, West*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Oak Lawn Cemetery *April 11, 1920*

20-UNDERTAKER

ADDRESS

William E. Schaeffer *1816 Monument*

CAUSE OF DEATH is important. See instructions on back of certificate.

D42131

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42131

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST.; *3* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mr Samuel Hoffman*(Residence in Baltimore: No. *255 S Edmond St.* St.; *16* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*white*5-SINGLE,
MARRIED, *married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Unknown
(Month) (Day) (Year)

7-AGE,

48 yrs. — mos. — ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*Russia*

PARENTS.

10-NAME OF FATHER,

*Harry Hoffman*11-BIRTHPLACE OF FATHER
(State or Country),*Russia*

12-MAIDEN NAME OF MOTHER

*Fannie Gelman*13-BIRTHPLACE OF MOTHER
(State or Country),*Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harry Hoffman*(Address) *255 S Edmond St.*

15-

Filed

APR 11 1920

ROBERT E. KRAUTER

Burial Place Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 11, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

4-7-1920, to *4-11-1920*,that I saw him alive on *4-11-1920*,and that death occurred, on the date stated above, at *4:30 am.*

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis
Generalized Tbc.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY

Post vesicle Tbc. ulcers

(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Harry Hoffman* M. D.*4-11-1920* (Address) *Hebrew Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the.....yrs.....mos.....ds. State.....

Where was disease contracted, if not at place of death?

Former or usual residence

255 S Edmond St

19-PLACE OF BURIAL OR REMOVAL,

Hebrew Hospital

DATE OF BURIAL,

April 11, 1920

20-UNDERTAKER

Max Linson

ADDRESS

2127 E Balto St

D42132

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.;

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Frances Dilworth.(a) RESIDENCE. NO. Long Green, Md.
(Usual place of abode)

ST. WARD.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married.5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofEmma Dilworth6 DATE OF BIRTH (month, day, and year) Unknown 18537 AGE Years Months Days If LESS than 1 day, hrs. or min.
67.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer.(b) General nature of industry, business, or establishment in which employed (or employer) ----

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)10 NAME OF FATHER Frances Dilworth11 BIRTHPLACE OF FATHER (city or town) Ireland.
(State or country)12 MAIDEN NAME OF MOTHER Unknown.13 BIRTHPLACE OF MOTHER (city or town) Unknown.
(State or country)14 Informant M. E. Dilworth
(Address) Baltimore Md.15 APR 11 1920 ROBERT B. KRAUTER
Registrar
Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 192017 I HEREBY CERTIFY. That I attended deceased from March 30, 1920, to April 10, 1920, that I last saw him alive on April 10, 1920, and that death occurred, on the date stated above, at 11:05 A.M. The CAUSE OF DEATH* was as follows:
Right lobar pneumonia.(duration) yrs. mos. 7 ds.CONTRIBUTORY Compound fracture right forearm
(Secondary) and dislocation right shoulder
(duration) yrs. mos. 11 ds.18 Where was disease contracted
if not at place of death? -----Did an operation precede death? YES Date of 3/30/20Was there an autopsy? NO.What test confirmed diagnosis? Clinical evidence.(Signed) W. H. Allen, M. D.19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Fort. M. E. Dilworth Md.4/13 1920

20 UNDERTAKER

John J. Lawrence & Son

ADDRESS

307 Baltimore St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42133

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2076 Plynmouth Ave

ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Michael Joseph Ferry

St. 36 yrs. 11 mos. 26 ds.)

(Residence in Baltimore: No. 2076 Plynmouth

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH.

April 22

1875

1920

(Month)

(Day)

(Year)

7-AGE.

44

yrs. 11 mos. 16 ds.

IF LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

modeler

(b) General nature of industry, business, or establishment in which employed (or employer)

Iron

9-BIRTHPLACE,

(State or Country).

Ireland
Co Louth

10-NAME OF FATHER.

Unknown

11-BIRTHPLACE OF FATHER

(State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Mabel Ferry

(Address)

2076 Plynmouth Ave

15-

APR 12 1920

ROBERT A. KRAUTER

SPECIAL FOREMAN

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

4

8

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from April 3 1920, to April 8 1920, that I saw him alive on April 7 1920, and that death occurred, on the date stated above, at 19. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

Tuberculosis

(Duration)....yrs....mos....ds.

(Signed) Chas. F. Connelley M. D.

481, 1920 (Address) 3704 Plynmouth Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Holy Cross A.C.C.

DATE OF BURIAL.

4-12-1920

20-UNDERTAKER

E. B. Harker

ADDRESS

115 E West St

D42134

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D42134

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3108 Anchenbury Ter* ST.; *13* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Thomas W. Catling*(Residence in Baltimore: No. *3108 Anchenbury Ter* St.; *35* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widowed*
(Write the word.)

6-DATE OF BIRTH, *April 18th, 1848*
(Month) (Day) (Year)

7-AGE, *74* yrs. *11* mos. *7* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Retired*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *England*

10-NAME OF FATHER, *Geo. Catling*
11-BIRTHPLACE OF FATHER (State or Country), *England*
12-MAIDEN NAME OF MOTHER, *Elizabeth Warr*
13-BIRTHPLACE OF MOTHER (State or Country), *England*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Thomas W. Catling*(Address) *3005 Chestnut Ave*

15- *APR 12 1920* *ROBERT E. TEAUTE*
Filed....., 191... *Regist.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 11th, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 9, 1920*, to *April 11, 1920*, that I saw him alive on *April 11, 1920*, and that death occurred, on the date stated above, at *12:45* m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis, Senility
Terminal coma

(Duration) *5* yrs. mos. ds.

CONTRIBUTORY *Chronic Endocarditis*
(Secondary)

(Duration) *19* yrs. mos. ds.

(Signed) *Maurice E. Thomas, M. D.*

April 12, 1920 (Address) *330a N. North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Smith Ridge* DATE OF BURIAL, *Apr. 13, 1920*

20-UNDERTAKER *Galvan F. Walker* ADDRESS *7230 Hwy 915*

Dr. Schumacher 3305 W. 7th Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42135

CERTIFICATE OF DEATH.

152 D42135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3009 Roseland Pl* ST. *15* WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. *3009 Roseland Pl* St. *15* yrs. *7* mos. *10* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

MEDICAL CERTIFICATE OF DEATH.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

*April**10**1920*

(Month)

(Day)

(Year)

7-AGE,

7 yrs. *7* mos. *10* ds.

If LESS than 1 day, (6 hrs. to 15 min.)

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Balto Md

10-NAME OF FATHER,

Clyde E Miller

11-BIRTHPLACE OF FATHER (State or Country),

Bloomington Md

12-MAIDEN NAME OF MOTHER

Wabell Hays

13-BIRTHPLACE OF MOTHER (State or Country),

Charleston W Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Clyde E Miller*(Address) *3009 Roseland Pl*

15-

Filed

APR 2 1920

ROBERT H. LEAUTEK

Serial Form No. 10-1-1

16-DATE OF DEATH

*April**10**1920*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

*Birth 4/10 1920, to death 4/10 1920*that I saw him alive on *4-10-1920*and that death occurred, on the date stated above, at *6:45 P.M.*

The CAUSE OF DEATH* was as follows:

Acute asphyxia - gradual

CONTRIBUTORY (Secondary)

(Duration) *7* yrs. *7* mos. *10* ds.(Signed) *Clyde E Miller* M. D., 191... (Address) *3123 N. W. Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *7* yrs. *7* mos. *10* ds. In the State *7* yrs. *7* mos. *10* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Woodlawn Cem.

DATE OF BURIAL,

April 1, 1920

20-UNDERTAKER

Joseph Syfer

ADDRESS

1600 W. W. Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42136

CERTIFICATE OF DEATH.

D42136

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 N. Curley ST.; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert E. Worsham(a) RESIDENCE. No. 20 N. Curley ST., 6 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of Mary E. Worsham (or) WIFE of6 DATE OF BIRTH (month, day, and year) March 25, 18917 AGE Years 79 Months 16 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Moulder(b) General nature of industry, business, or establishment in which employed (or employer) Retired 15 years

(c) Name of employer

9 BIRTHPLACE (city or town) Balto M (State or country) M. D.10 NAME OF FATHER John Worsham11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)12 MAIDEN NAME OF MOTHER Katherine Gray13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)14 Informant Joseph Worsham (Address) 20 N. Curley St15 Filed APR 12 1920 ROBERT B. ELLIOTT Registrar

Burial Permit 01071

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 192017 I HEREBY CERTIFY, That I attended deceased from April 1, 1919 to April 9, 1920, that I last saw him alive on April 9, 1920, and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Sarcema of the face(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.4.11.1920 (Address) 120 1/2 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Carmel Cem. April 12 1920

20 UNDERTAKER

ADDRESS

J. Sander & Sons 1701 Cat St

Chalk
HEALTH DEPARTMENT—CITY OF BALTIMORE

D42137

CERTIFICATE OF DEATH.

79 D42137

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2719 Huntington ST.* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary E Chalk*(a) RESIDENCE. No. *2719 Huntington ST.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *64* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Charles Chalk*6 DATE OF BIRTH (month, day, and year) *May 15 1855*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
64 *10* *27*8 OCCUPATION OF DECEASED *Retired*

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *MD*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Eliza Swindle*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*14 Informant *Charles Chalk* (Address) *2719 Huntington ST.*15 *APR 12 1920* *ROBERT B KAUTER* Registrar

Burial Permit Class

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 10 1920*17 I HEREBY CERTIFY, That I attended deceased from *February* 1920 to *April 11* 1920, that I last saw him alive on *April 11 1920*, and that death occurred, on the date stated above, at *7:25 P.* m. The CAUSE OF DEATH* was as follows:*Myocardial degeneration*
(duration) *2* yrs. mos. ds.
CONTRIBUTORY *Dilatation of the heart.* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *George M. Smith* M. D. Address *2435 Maryland Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St Marys Hampden *Apr 13 1920*

20 UNDERTAKER ADDRESS

Chenoweth Son *Chesnut*

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42138

CERTIFICATE OF DEATH.

151 D42138

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 N. Glover ST.; 6 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 112 N. Glover St.; 6 yrs., 0 mos. 0 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single (Write the word.)6-DATE OF BIRTH. April 10, 1920
(Month) (Day) (Year)7-AGE. 0 yrs. 0 mos. 0 ds. IF LESS than 1 day, 4 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). None9-BIRTHPLACE, (State or Country), Ind.PARENTS.
10-NAME OF FATHER, George M. Hack
11-BIRTHPLACE OF FATHER (State or Country), Ba Co.
12-MAIDEN NAME OF MOTHER, Caroline M. Hoff
13-BIRTHPLACE OF MOTHER (State or Country), Ba Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. M. Hack(Address) 112 N. Glover

15-

APR 12 1920
Filed 1920 ROBERT R. LAUTER
Bureau of Registration

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 10, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 10, 1920, to April 10, 1920, that I saw him alive on April 10, 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth
seven months
(Duration) 0 yrs. 0 mos. 0 ds.CONTRIBUTORY (Secondary) None(Signed) W. H. Heaver M. D.
4/11, 1920 (Address) 2600 N. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Sacred Heart Church

DATE OF BURIAL

April 12, 1920

20-UNDERTAKER

Lily and Ziller

ADDRESS

403 S. Wolfe St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

042139

CERTIFICATE OF DEATH

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 1724 W. Fayette

ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pierce Ryan

(Residence in Baltimore: No. 1724 W. Fayette

Str. 66 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widower

6-DATE OF BIRTH

Dec 24, 1833
(Month) (Day) (Year)

7-AGE

66 yrs. 3 mos. 15 ds.

If LESS than
1 day, hrs.
or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

9 BIRTHPLACE
(State or country)

Petersburg Va

10 NAME OF FATHER

Pierce Ryan

11 BIRTHPLACE OF FATHER
(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Anne Whiteford

13 BIRTHPLACE OF MOTHER
(State or country)

Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. Virginia Ryan

(Address)

1724 W. Fayette St.

15.

Filed

APR 12 1920

ROBERT B. KAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

April 9, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 28 - 1920 to April 9 1920.

that I saw him alive on April 8 - 1920.

and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 18 mos. ds

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

J. B. [Signature]

M. D.

APR 9 1920

(Address) PROFESSIONAL BUILDING

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Baltimore (Cem)

DATE OF BURIAL

Apr 12, 1920

20-UNDERTAKER

Joseph B. Cook

ADDRESS

1003 N. Baltimore St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42140

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *441 W Lexington St.* ST.: *18* WARD)

2-FULL NAME

(Residence in Baltimore: No. *941 W Lexington St.*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH

Dec 15, 1853
(Month) (Day) (Year)

7-AGE

66 yrs. *3* mos. *24* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER, (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

APR 12 1920

ROBERT B. KRAUTER

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 9, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy, or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broken neck from fall down stairs(Duration) yrs. *a few min.* mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. B. Gorman* M. D. (Coroner.)*4-10-1920* (Address) *117 W. Saratoga*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park *Apr. 13, 1920*

20-UNDERTAKER

ADDRESS

Joseph B. Cook *1003 W. Bold St. Baltimore*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42141

CERTIFICATE OF DEATH.

79 D42141
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 Greenmount ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Frederick Enrich

(a) RESIDENCE. No. 1034 Greenmount ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 9 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

no

6 DATE OF BIRTH (month, day, and year) 8-12-1909

7 AGE

Years 10

Months 9

Days mo

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER John F. Enrich

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Margaret Garvey

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14

Informant (Address) 126 Lexington St.

15

APR 12 1920

J. F. RAUTER Registrar

Burial Permit 1087

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 7, 1915, to April 8, 1920, that I last saw him alive on April 8, 1920.

and that death occurred, on the date stated above, at 8:00 p.m.

The CAUSE OF DEATH* was as follows:

Coronary Atherosclerosis and Valvular Heart Disease (Mitral)

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted

if not at place of death? 1034 Greenmount

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. C. Burns, M. D.

, 19 (Address) 221 824

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

4/12 1920

20 UNDERTAKER

ADDRESS

C. J. Fanning 1938 E. Lexington St.

D42142

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 210 South 8th ST.: 26 WARD)2-FULL NAME Terressa Spain(Residence in Baltimore: No. 210 South 8th

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Jan 15, 1868
(Month) (Day) (Year)

7-AGE,

52 yrs. 2 mos. 27 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Spain(Address) 210 South 8th

15-

Filed

APR 12 1920

ROBERT H. KAUTER

Racial P. 100-1000

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jan 11, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an...
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said...
(Inquest, au-topsy or inquiry.) and that said deceased came to... death
on the day stated above.

The CAUSE OF DEATH* was as follows:

(Duration).... yrs.... mos.... ds.

CONTRIBUTORY
(Secondary)

(Duration).... yrs.... mos.... ds.

(Signed) Henry E. Boush M. D.(Coroner.)
(Address) 100 E. Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death.... yrs.... mos.... ds. State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

042143

HEALTH DEPARTMENT—CITY OF BALTIMORE

042143

CERTIFICATE OF DEATH.

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.) Maryland General Hosp St.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret R. Grund

(Residence in Baltimore: No. 151 N. Lakewood Ave.

Life
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female
4-COLOR OR RACE, White
5-SINGLE, MARRIED, Married
WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, July 29, 1873.
(Month) (Day) (Year)7-AGE, 46 yrs. 9 mos. 7 ds.
If LESS than 1 day,hrs. ormin.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, Joseph Knight

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Mary E. Carter

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles L. Grund

(Address) 151 N. Lakewood Ave.

15- APR 12 1920 DOBNEY & KAUTER

Filed, 191 Serial Form No. 1000

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 9, 1920, 191...
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said
(Inquest, au-Inquiry and that said deceased came to death
(topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Brights Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY Uremia
(Secondary)

(Duration) yrs. mos. ds.

(Signed) F. E. v. Smith M. D.

(Coroner)

Apr 10 1920 (Address) 90 C. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 yrs. 4 mos. 46 ds. In the State

Where was disease contracted, if not at place of death?

Former or usual residence 151 N. Lakewood Ave.

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, 4-13, 1920

20-UNDERTAKER, Wm Cook ADDRESS 502 E. North Ave.

important. See instructions on back of certificate.

Etheridge 10 42144

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *50 Joseph St.* ST.: *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Fredrick Etheridge

(a) RESIDENCE. NO.

214 Prentiss

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

4

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Y

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND (or) WIFE of

Nettie Etheridge

6 DATE OF BIRTH (month, day, and year)

June 29-1883

7 AGE

36

Months

4

Days

12

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

England

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

England

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

England

14

Informant (Address)

Nettie Etheridge 214 E Prentiss

15

File

*APR 12 1920**ROBERT A. KAUTER*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 11 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*March 25 1920, to April 11 1920,*that I last saw him alive on *April 11 1920,*and that death occurred, on the date stated above, at *8 9* m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration following degenerative disease

(duration)

yrs.

mos.

2 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *March 27-20*Was there an autopsy? *Yes*What test confirmed diagnosis? *Specimen*

(Signed)

J. T. Damm

M. D.

19

(Address)

St Joseph (Hospital)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Baltimore**Apr 14 1920*

19

20 UNDERTAKER

ADDRESS

Wm Coats 602 E North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 Portland ST.; 21 WARD)REGISTERED NO. C. 89-142145

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adolph B. Brandt(Residence in Baltimore: No. 717 Portland St.; 29 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH. June 6, 1890
(Month) (Day) (Year)7-AGE, 29 yrs., — mos., — ds. If LESS than 1 day,hrs. or....min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House Painter
(b) General nature of industry, business, or establishment in which employed (or employer) —9-BIRTHPLACE, (State or Country), Balt Md10-NAME OF FATHER, Wm Brandt11-BIRTHPLACE OF FATHER (State or Country), Richmond Va12-MAIDEN NAME OF MOTHER, Annie L. Darich13-BIRTHPLACE OF MOTHER (State or Country), Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Brandt Jr(Address) 717 Portland St

15-

APR 12 1920

Filed

ROBERT H. KRAUTER

Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 11, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 2, 1920, to April 11, 1920, that I saw him alive on April 10, 1920, and that death occurred, on the date stated above, at 5 m. The CAUSE OF DEATH* was as follows:
Over
acute Bronchitis
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....(Duration).....yrs.....mos.....ds.

(Signed) Harry Boyd M. D.April 11, 1920 (Address) 1412 Columbia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery DATE OF BURIAL, April 13, 192020-UNDERTAKER, Geo. L. Lumbach & Son ADDRESS, 677 N. Bond St

D42146

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D42146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 743 Foundry Court WARD 221)

2-FULL NAME

Mary Koplak

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 743 Foundry Court WARD 221
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 20 19197 AGE Years Months Days If LESS than 1 day, hrs. or min.
4 21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)10 NAME OF FATHER Peter Koplak11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)12 MAIDEN NAME OF MOTHER Annie Melkale13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)14 Informant Peter Koplak
(Address) 743 Foundry Court15 APR 2 1920 JOSEPH I. KEAUTEBurial Permit 1140

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10 19 2017 I HEREBY CERTIFY, That I attended deceased from April 10, 19 20, to April 10, 19 20that I last saw him alive on April 10, 19 20and that death occurred, on the date stated above, at 108 m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James B. Boyd M. D.Address 620 W. 2nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer Cemetery April 12 19 20

20 UNDERTAKER ADDRESS

James F. Dignan & Son 1017 S. Paca St.

TUTION is very important. See instructions on back of certificates.

D42147

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D42147

PLACE OF DEATH

CITY OF BALTIMORE (No. 1003 E 1st St)

St. 3

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William Kovak

(Residence in Baltimore: No. 1003 E 1st St X)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

Oct 23, 1920
(Month) (Day) (Year)

7-AGE,

1 yr. 6 mos. 6 wks. 6 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Dependant

9-BIRTHPLACE, (State or Country),

Baltimore MD

10-NAME OF FATHER,

Peter Kovak

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Martha Samuel

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Peter Kovak

(Address)

1003 E 1st St X

15-

APR 12 1920

ROBERT B. KRAUTH

Filed

191

Baptist Church

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 11, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute myocardial infarction

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry G. D. D.

(Address) 1610 E 1st St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Family

April 12 1920

20-UNDERTAKER

ADDRESS

Wendell Ruffel

378 Ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42148

CERTIFICATE OF DEATH.

113 D42148
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Abraham(Residence in Baltimore: No. 1252 N Gay St.; 5 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

M

4-COLOR OR RACE,

W5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

June, 1873
(Month) (Day) (Year)

7-AGE,

46 yrs., 10 mos., 0 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....Watchman
0399-BIRTHPLACE,
(State or Country).Baltimore10-NAME OF
FATHER,Martin Abraham11-BIRTHPLACE
OF FATHER
(State or Country)Poland12-MAIDEN NAME
OF MOTHEREllen Fallon13-BIRTHPLACE
OF MOTHER
(State or Country)Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mayant & Schantz(Address) 1252 N Gay

15-

APR 21 1920

ROBERT B. BRAUTER

BRIEF EXAMINER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

4-11, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

3-17, 1920, to 4-11, 1920,that I saw him live on 4-11, 1920,and that death occurred, on the date stated above, at 2456.

The CAUSE OF DEATH* was as follows:

Carburettion of the liver

.....

.....

.....

..... (Duration)..... yrs. 2 mos. ds.CONTRIBUTORY.....
(Secondary)..... (Duration)..... yrs. 1 mos. 15 ds.(Signed) Harry G. Schantz, M. D.4-11, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

New Catholic

DATE OF BURIAL,

Apr. 13, 1920

20-UNDERTAKER

Robt Schantz

ADDRESS

1442 N Gay

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42149

CERTIFICATE OF DEATH.

9 D42149

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs. 6 mos. 20 ds.

How long in U. S. If of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD)

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

APR 12 1920

ROBERT E. REAUTE Registrar

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from April 10, 1920, to April 11, 1920, that I last saw him alive on April 11, 1920, and that death occurred, on the date stated above, at 8:45 P. M.

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) P. Magowan, M. D.

, 1920 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42150

CERTIFICATE OF DEATH.

30 D42150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *934 N. Patterson Pk Ave* ST.; *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Margaret M. Schoppert*(a) RESIDENCE. No. *934 N. Patterson Pk Ave*, WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2 1/2* yrs. mos. ds. How long in U. S., if of foreign birth? *7* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *Jan 7 / 1913*7 AGE Years *7* Months *3* Days *4* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Harry Schoppert*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *W. Va.*12 MAIDEN NAME OF MOTHER *Jadie Splain*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Balto.*14 Informant *Jadie Schoppert*(Address) *934 N. Patterson Pk Ave*15 Filed *APR 12 1920* *ROBERT E. FFAUTER* Registrar*Burial permit 01088*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *APR 11 1920*17 I HEREBY CERTIFY, That I attended deceased from *April 3*, 19*20*, to *April 12*, 19*20*, that I last saw her alive on *April 10*, 19*20*, and that death occurred, on the date stated above, at *6:10 A. m.*

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis(duration) yrs. mos. ds. *25*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Spinal fluid + b. bacilli found*(Signed) *Benj. Sappan*, M. D., 19 (Address) *1102 North Charles St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Cem

DATE OF BURIAL

APR 14 1920

20 UNDERTAKER

Ceo. M. Fink & Son,

ADDRESS

811 N. Wolfe

Funeral Directors & Embalmers.

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42151

CERTIFICATE OF DEATH.

+ 28

D42151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Church Home ^{and Inf.} ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mr. Henry Keenard

(Residence in Baltimore: No.

Church Home

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widowed

6-DATE OF BIRTH,

April

(Month)

1883

(Day)

(Year)

7-AGE,

77 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

retired

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Kent Co Md

10-NAME OF FATHER,

Thomas C. Keenard

11-BIRTHPLACE OF FATHER,

(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Jane Thuron

13-BIRTHPLACE OF MOTHER,

(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Henry H. Keenard

(Address)

Alderdecree Md

15-

APR 12 1920

ROBERT A. ERAUTER

Filed..... 191.

Baltimore

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April

10

(Day)

1920

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

Feb. 14, 1920, to April 10, 1920,

that I saw him alive on April 10, 1920,

and that death occurred, on the date stated above, at 11:15 p.m.

The CAUSE OF DEATH* was as follows:

Lungs and glands of neck.
Tuberculosis, with general
anemia.

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed)

Walter T. Anderson M. D.

April 10, 1920, (Address) Church Home and Inf.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Westminster Md

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

London Park

Apr 12, 1920

20-UNDERTAKER

ADDRESS

John Ormitchell 1301 N. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42152

CERTIFICATE OF DEATH.

10-119 D42152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Scott St. ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Marguerh Barnes(a) RESIDENCE. No. 1014 Scott St. ST. 21 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 5 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced (or) WIFE of George W. Barnes6 DATE OF BIRTH (month, day, and year) Oct 12 18807 AGE Years 39 Months 5 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balta, Md. (State or country)10 NAME OF FATHER John A. Silberzahn11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Mary Vetter13 BIRTHPLACE OF MOTHER (city or town) Balta, Md. (State or country)14 Informant George W. Barnes (Address) 1014 Scott St.15 Filed APR 12 1920 ROBERT I. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10-2017 I HEREBY CERTIFY, That I attended deceased from April 1, 1920, to April 10, 1920, that I last saw him alive on April 10, 1920, and that death occurred, on the date stated above, at 730 m. The CAUSE OF DEATH* was as follows:Acute Interstitial NephritisCONTRIBUTORY (Secondary) Group - (duration) yrs. mos. 10 ds.(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) Shepherd Davis M. D. (Address) 627 Chambers St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem DATE OF BURIAL Oct. 13 192020 UNDERTAKER Mr. Mrs. John H. Zenzel ADDRESS 801 W. Fayette

TION is very important. See instructions on back of certificates.

D42153

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42153

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If 1. LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).9-BIRTHPLACE,
(State or Country),10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country),12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

Robert P. Harrison,

APR 12 1920 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mar 20 1920, to 4 - 10 1920,

that I saw h^e alive on 4 - 9 1920,

and that death occurred, on the date stated above, at 2:00 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma, uterus

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. J. Demaree, M. D.

4/18, 1920 (Address) 914 E. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-
SIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Cathedral April 13, 1920
H.C. Weddefield 914 Biddle St.

D42154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42154

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital.*

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Baby Rice*(a) RESIDENCE. NO. *420 Hutchins Ave*
(Usual place of abode)

ST.:

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*Black*5 Single, Married, Widowed,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Apr. 6, 1920*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Md.*

10 NAME OF FATHER

*George Moore*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*N.C.*

12 MAIDEN NAME OF MOTHER

*Hattie Rice*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Md.*

14

Informant
(Address)*W. W. Gray*

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 8,* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 6, 19*20*, to *Apr. 8,* 19*20*.that I last saw him alive on *Apr. 8,* 19*20*.and that death occurred, on the date stated above, at *3:45 P.* m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

John W. Harris, M. D.

#9, 1920 (Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*JOHNS HOPKINS HOSPITAL**April 9, 1920*

20 UNDERTAKER

ADDRESS

*Commissioner Health,**W. W. WOODALL*

TION is very important. See instructions on back of certificates.

APR 12 1920

Burial Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42155

D42155

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 Frederick ST.; 25 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Louise E. Baughan(Residence in Baltimore: No. 503 Frederick St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married
(Write the word.)6-DATE OF BIRTH, Aug -, 1878
(Month) (Day) (Year)7-AGE, 42 yrs., mos., ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housewife (b) General nature of industry, business, or establishment in which employed (or employer), 9-BIRTHPLACE, (State or Country), Ind10-NAME OF FATHER, Unknown11-BIRTHPLACE OF FATHER (State or Country), Ind12-MAIDEN NAME OF MOTHER Louise Harbrett13-BIRTHPLACE OF MOTHER (State or Country), Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. W. Baughan(Address) Brooklyn

15-

Robert P. Harrison,

APR 12 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr, 12, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from March 20, 1920, to Apr 12, 1920, that I saw him alive on Apr 11, 1920, and that death occurred, on the date stated above, at 1:30 a.m. The CAUSE OF DEATH* was as follows:Chronic Dysentery(Duration) 2 yrs., 2 mos., ds.CONTRIBUTORY Extension
(Secondary)(Duration) yrs., mos., ds.(Signed) Charles H. Smith M. D.Apr 12, 1920 (Address) Brooklyn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence 19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery DATE OF BURIAL, 4-14, 192020-UNDERTAKER Wm. Cook ADDRESS 502 E North Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mount Hope Rehab* ST.; *28th* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Mount Hope Rehab* St.; *10* yrs., *0* mos., *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

Aug 19th 1885
(Month) (Day) (Year)

7-AGE,

34 yrs., *7* mos., *24* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*None*9-BIRTHPLACE,
(State or Country),*Pittsburg Pa*

10-NAME OF FATHER,

*Thomas Paul Bedillion*11-BIRTHPLACE OF FATHER
(State or Country)*Wheeling W. Va*

12-MAIDEN NAME OF MOTHER

*Shumah De Haven*13-BIRTHPLACE OF MOTHER
(State or Country),*Allegheny City Pa*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Records of Mt Hope Rehabil.*(Address) *Mt Hope Rehabil.*

15-

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 12th 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *March 28th 1910* to *April 12th 1920*, that I saw her alive on *April 11th 1920*, and that death occurred, on the date stated above, at *3:15* m. The CAUSE OF DEATH* was as follows:*Chr. Fibroid Phthisis**abt* (Duration) *10* yrs., *0* mos., *0* ds.CONTRIBUTORY
(Secondary)*Chronic Mania* (Duration) *10* yrs., *0* mos., *0* ds.(Signed) *Frank J. Flannery* M. D.*4/12/20*, *1920* (Address) *Mt Hope Rehabil.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *10* yrs., *0* mos., *0* ds. In the State *10* yrs., *0* mos., *0* ds.Where was disease contracted, if not at place of death? *Pittsburg Pa*Former or usual residence *Pittsburg Pa*

19-PLACE OF BURIAL OR REMOVAL,

Pittsburg Pa

DATE OF BURIAL,

April 23, 1920

20-UNDERTAKER

W. J. Trickett

ADDRESS

NY Pa

APR 12 1920

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

150 ✓ 042157

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1318 Homewood Ave

ST. 9 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmer W. Albau

(Residence in Baltimore: No. 1318 Homewood Ave

St. yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

Feb

18, 1920

(Month)

(Day)

(Year)

7-AGE

yrs.

1 mos.

24 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE (State or country)

Balti. City

10-NAME OF FATHER

Harry W. Albau

PARENTS

11-BIRTHPLACE OF FATHER (State or country)

Md.

12-MAIDEN NAME OF MOTHER

Mary Talbot

13-BIRTHPLACE OF MOTHER (State or country)

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. H. Robinson

212 E. Preston St

Robert P. Harrison

15.

APR 12 1920 Burial Permit Clerk,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

April

11

1920

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 18, 1920, to April 11, 1920,

that I saw him alive on April 11, 1920,

and that death occurred on the date stated above, at 7:30 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial infarction

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

Exhaustion

(Duration) yrs. mos. ds.

(Signed) J. H. Robinson M. D.

April 12, 1920 (Address) 212 E. Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Mary's Hospital

DATE OF BURIAL

Apr 13, 1920

20-UNDERTAKER

A. J. Marshall

ADDRESS

3529 1/2 Rd

D42158

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42158

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

808 N. 35th St.

ST.: 13 WARD)

2-FULL NAME

Mary Ida Hilhelm

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

3710 Carver Lane

ST.: 13 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John J. Hilhelm

6 DATE OF BIRTH (month, day, and year)

Aug. 12-1856

7 AGE

Years

Months

Day

If LESS than 1 day. hrs. or min.

63

7

30

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

New Market Pa.

10 NAME OF FATHER

Joshua Downe

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Catherine J. Hartley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa.

14

Informant (Address)

John J. Hilhelm 3710 Carver Lane

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 11 1920.

17

I HEREBY CERTIFY, That I attended deceased from

Jan 7, 1920, to April 11, 1920.

that I last saw her alive on April 8, 1920.

and that death occurred, on the date stated above, at 3:18 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus & metastasis

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Hilhelm M. D.

(Address) 3849 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mary's Hampden

April 13 1920.

20 UNDERTAKER

Horace Burgee & Son 363 Fall Rd.

TION is very important. See instructions on back of certificates.

PRI 2 1920

D42159

HEALTH DEPARTMENT—CITY OF BALTIMORE

042159

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital)ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Kott(a) RESIDENCE. No. 1616 Thomas St

(Usual place of abode)

ST. _____ WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) Bohemia
(State or country)10 NAME OF FATHER John Marcheck11 BIRTHPLACE OF FATHER (city or town) Bohemia
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Bohemia
(State or country)14 Informant Hospital Records(Address) New City Hospital15 Filed Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1920

17 I HEREBY CERTIFY, That I attended deceased from December 18, 1919 to April 11, 1920, that I last saw her alive on April 11, 1920, and that death occurred, on the date stated above, at 10:15 A.M.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis (General & Cerebral)CONTRIBUTORY
(Secondary)

? (duration) yrs. mos. ds.

Myocardial insufficiency
? (duration) yrs. mos. ds.18 Where was disease contracted ?
if not at place of death?Did an operation precede death? No, Date of _____Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. D. Stalling M. D.4-11-20 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy RedeemerApril 13, 1920

20 UNDERTAKER

ADDRESS

Paul Oracher

APR 12 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42160

D42160

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hosp.*ST.: *24* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *William White*(a) RESIDENCE. NO. *1092 Riverside*

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. *3* mos. *9* ds. How long in U. S., if of foreign birth? *50* yrs. *3* mos. *9* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Single*6 DATE OF BIRTH (month, day, and year) *July 3 - 1870*7 AGE Years *49* Months *3* Days *9* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Drives at.

(b) General nature of industry, business, or establishment in which employed (or employer)

Matthai Ingram

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto Md.*10 NAME OF FATHER *Wm. White*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Howard Co*12 MAIDEN NAME OF MOTHER *Lucy Ruby*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Howard Co

14

Informant (Address)

Mrs. Hood Robert B. Harrison

APR 12 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4 - 12* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from *March 23*, 19 *20*, to *April 12*, 19 *20*that I last saw him alive on *April 12*, 19 *20*and that death occurred, on the date stated above, at *11:06* m.

The CAUSE OF DEATH* was as follows:

Morbidial suffocation(duration) yrs. mos. *1* ds.

CONTRIBUTORY (Secondary)

Strangulated hernia (duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *3-24-20*Was there an autopsy? *no*What test confirmed diagnosis? *Hematoxylin*(Signed) *J. T. Darr*, M. D., 19 (Address) *St Joseph's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cedar Hill Cemetery**4/15* 19 *20*

20 UNDERTAKER

ADDRESS

*J. F. M. Bulby**130 E. Fort.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42161

CERTIFICATE OF DEATH.

28 ✓ D42161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 N ChapelST.: 6

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Wallis(a) RESIDENCE. NO. 130 N Chapel

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 35 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F4 COLOR OR RACE Col5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Wallis6 DATE OF BIRTH (month, day, and year) unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 35

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer none at present9 BIRTHPLACE (city or town) Montgomery
(State or country) Alabama10 NAME OF FATHER Geo William11 BIRTHPLACE OF FATHER (city or town) Mad(State or country) unintelligible12 MAIDEN NAME OF MOTHER Johnnie Taylor13 BIRTHPLACE OF MOTHER (city or town) Mad(State or country) unintelligible

14

Informant Mary Mills
(Address) 130 N Chapel

15

Filed APR 13 1920

ROBERT E. KRAUTER

Registrar

Serial 1000000000

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr 1, 1920, to Apr 11, 1920.that I last saw him alive on Apr 11, 1920.and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis lungs(duration) 1 yrs. 6 mos. 0 ds.CONTRIBUTORY (Secondary) Encephalitis 2 1918(duration) 3 yrs. 0 mos. 0 ds.

18 Where was disease contracted

if not at place of death? 130 N ChapelDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Tuberculosis(Signed) W. C. Burns, M. D., 19 (Address) 2215 Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Deal Island. Md.April 13 1920

20 UNDERTAKER

ADDRESS

Milton Davis 413 N Eden St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42162

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Women's Hospital, Baltimore

ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mrs. Maud Henson

(Residence in Baltimore: No.

Women's Hospital

St.; yrs., mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

married

6-DATE OF BIRTH.

April

21

1874

(Month)

(Day)

(Year)

7-AGE.

46

yrs. 11 mos. 11 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE.

(State or Country),

Harford Co., Md.

10-NAME OF FATHER,

Dr. W. B. Rowe

11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore Co., Md.

12-MAIDEN NAME OF MOTHER

Carrie Burroughs

13-BIRTHPLACE OF MOTHER

(State or Country),

Perryopolis

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. B. Rowe

(Address)

415 W. North Ave.

15-

APR 13 1920

ROBERT B. KEAUTER

Filed

191

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

April

11

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 23 1920

to

April 11, 1920

that I saw her alive on

April 11, 1920

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Secondary Anemia

(Etiology unknown)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY

(Secondary)

Operation - myocardial

(Duration).....yrs.....mos.....ds.

(Signed)

Frank J. Thompson, M. D.

April 11, 1920 (Address) Women's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

of death

yrs.

mos.

18

ds.

In the

State

yrs.

mos.

18

ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

1802 1/2 Delaware Ave, Wilmington

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

London Park

April 13, 1920

20-UNDERTAKER

ADDRESS

Henry Jenkins & Co. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42163

CERTIFICATE OF DEATH.

X 40 D42163

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hospital ST.: 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1200 E. Baltimore St St.: 3 yrs., 18 mos., 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

April 2
(Month) (Day) (Year)1891
(Year)

7-AGE,

29 yrs., 18 mos., 18 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Operator in db
Establishment9-BIRTHPLACE,
(State or Country),Russia

PARENTS.

10-NAME OF FATHER,

Frank Pasenthal

11-BIRTHPLACE OF FATHER

(State or Country), Russia

12-MAIDEN NAME OF MOTHER

Gertrude Blumenthal

13-BIRTHPLACE OF MOTHER

(State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Miller(Address) 2023 Penna Ave

15-

Filed APR 13 1920

ROBERT B KRAUTER

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 11
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Dec 24 1919, to April 11 1920,that I saw her alive on April 11 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach in
adventitious scar 2 in
incision ant. abdominal(Duration) 2 yrs., 18 mos., 18 ds.

CONTRIBUTORY

(Secondary)

(Duration) 3 yrs., 18 mos., 18 ds.(Signed) Alfred P. Lohr M. D.April, 1920 (Address) 1112 E. Canton St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs., 18 mos., 18 ds. In the State 14 yrs., 18 mos., 18 ds.Where was disease contracted, if not at place of death? Probably near BaltimoreFormer or usual residence New York City

19-PLACE OF BURIAL OR REMOVAL,

Bethel Behren

DATE OF BURIAL,

4-13-20, 1920

20-UNDERTAKER

Jack Lewis

ADDRESS

1411 5th Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 W. Lexington St. ST.: 4 WARD)REGISTERED NO. 79 42167

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Rosental(a) RESIDENCE. NO. 725 W. Lexington St. ST.: 4 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) June 287 AGE Years 28 Months _____ Days _____ If LESS than 1 day, hrs. _____ or min. _____

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerical work

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Winkler11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Winkler13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant (Address) J Lewis 1411 E. Pratt St.

15

Filed APR 13 1920 ROBERT R. LELANDSerial 1411 E. Pratt St.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 192017 I HEREBY CERTIFY, That I attended deceased from June, 1920, to April 10, 1920, that I last saw him alive on April 10, 1920, and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Rupture of arch of aorta,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of _____Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Herman Liddel M. D., 19 (Address) 1931 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Friendship Cem4-13 1920

20 UNDERTAKER

ADDRESS

Jack Lewis1411 E. Pratt St.

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42165

CERTIFICATE OF DEATH.

37 D42165
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 Orchard St. ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 528 Orchard St. St.; 57 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widow
(Write the word.)

6-DATE OF BIRTH. April — 1868
(Month) (Day) (Year)

7-AGE. 57 yrs. 0 mos. 0 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.
10-NAME OF FATHER, Simon Smith
11-BIRTHPLACE OF FATHER (State or Country), Maryland
12-MAIDEN NAME OF MOTHER, Ellen Williams
13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Fulton(Address) 528 Orchard St.

15-

Filed APR 13 1920 191...
ROBERT B. BAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 10, 1920.
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Jan 4 1920, to Apr 9 1920, that I saw her alive on Apr 9 1920, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Dys
(Duration) 20 yrs 77 probability, ds.

CONTRIBUTORY none
(Secondary)

(Duration) 20 yrs 77 probability, ds.
(Signed) R B Fulton M. D.
Apr 10, 1920 (Address) 609 N Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Luke's DATE OF BURIAL, Apr 10, 1920.

20-UNDEERTAKER, Samuel Bailey ADDRESS St. Luke's

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42166

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1418 Morher ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1418 Morher St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OF RACE

Colored

5-SINGLE, ~~MARRIED~~WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Hallowan, 1893
(Month) (Day) (Year)

7-AGE,

27 yrs., mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Shipping clerk

9-BIRTHPLACE,
(State or Country),

Virginia

10-NAME OF FATHER,

James Scott

11-BIRTHPLACE OF FATHER
(State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Lena R. Lundy

13-BIRTHPLACE OF MOTHER
(State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lena Scott

(Address)

1418 Morher St.

15-

APR 13 1920

ROBERT N. KRAUTER

Filed..... 191.....

SPECIAL EXAMINER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

4 10, 1920
(Month) (Day) (Year)

17-HEREBY CERTIFY, That I attended deceased from Apr 3 1920, to Apr 10 1920, that I saw him alive on Apr 10 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Pneumonia

(Duration)..... yrs..... mos. 10 ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos. ds.

(Signed)..... M. D.

Apr 12, 1920 (Address) 1534 E. & An

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos. ds. In the State..... yrs..... mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

The Auburn Cem. Apr 13 1920

20-UNDERTAKER

ADDRESS

Samuel S. Stanley 518 E. 1st St.

D42167

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 931 Elm Place

ST. 17

WARD)

2-FULL NAME Rachel Dolon

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 931 Elm Place

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH,

Unknown, 1920
(Month) (Day) (Year)

7-AGE,

30

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Md.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Douglas

(Address) 534 W. Preston St.

15-

Filed APR 13 1920

ROBERT E. KAUFER

Baltimore Health Officer

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr. 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry, au-

topsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. E. Smith, M. D.

(Coroner) 4/12, 1920 (Address) 110 Light St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

Mt. Auburn Cem.

DATE OF BURIAL,

Apr. 14, 1920

20-UNDERTAKER

Samuel H. Under 578 W. 3rd St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42168

CERTIFICATE OF DEATH.

40

D42168

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital)ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Briggs(a) RESIDENCE. No. 1150 Carlton Ave.

ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18757 AGE Years Months Days If LESS than 1 day, hrs. or min. 45

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) Maryland
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)14 Informant Hospital Records(Address) New City Hospital.15 APR 13 1920 ROBERT F. KRAUTER
Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 192017 I HEREBY CERTIFY, That I attended deceased from April 5, 1920, to April 9, 1920,
that I last saw her alive on April 9, 1920,
and that death occurred, on the date stated above, at 11:00 P.m.

The CAUSE OF DEATH* was as follows:

Primary carcinoma of the gall bladderat least (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cerebral thrombosis
(duration) yrs. mos. ds. 318 Where was disease contracted if not at place of death? at homeDid an operation precede death? no Date ofWas there an autopsy? yes

What test confirmed diagnosis?

(Signed) Lawrence S. S., M. D.April 9, 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New City Hospital Apr 14 1920

20 UNDERTAKER

James L. Halsey 578 N. B.

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42169

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1519 Prestman ST.; 15 WARD)

2-FULL NAME

Rosa Stanley

(Residence in Baltimore: No. 1519 Prestman St.; 1 yrs., 9 mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

October

(Month)

1918 (Day) (Year)

7-AGE,

1 yrs., 9 mos., ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9-BIRTHPLACE, (State or Country),

Baltimore City

10-NAME OF FATHER,

William Stanley

11-BIRTHPLACE OF FATHER (State or Country),

MD

12-MAIDEN NAME OF MOTHER

Lauria Smith

13-BIRTHPLACE OF MOTHER (State or Country),

MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Stanley

(Address) 1519 Prestman St

15-

APR 13 1920

DEPT. OF HEALTH

1918

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April

(Month)

9

(Day)

1920 (Year)

I HEREBY CERTIFY, That I attended deceased from Mar 1 1920, to April 8 1920, that I saw her alive on April 8 1920, and that death occurred, on the date stated above, at 9:30 am.

The CAUSE OF DEATH* was as follows:

Subacute bronchitis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. J. Collins M. D.
Address 1039 McQuinn St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL,

McQuinn APR 13 1920

20-UNDERTAKER

ADDRESS

JAMES H. DENNIS

1303 PRESTMAN ST.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42170

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 Hollins

2-FULL NAME Fred Harding

(a) RESIDENCE. NO. 1006 Hollins

(Usual place of abode)
Length of residence in city or town where death occurred 11 yrs. mos.

ST.: 18 WARD)

ST.: WARD.

(If nonresident give city or town and State)
How long in U. S., if of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Babetta Maria Richmond

6 DATE OF BIRTH (month, day, and year) Feb. 1 - 1875

7 AGE 45

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Davis Chemical Works

(c) Name of employer

9 BIRTHPLACE (city or town) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany

14

Informant (Address) Babetta M. Harding 1006 Hollins

15

Filed

APR 13 1920

ROBERT E. ELLIOTT
BETHEL PRINCE CLERK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-11-1920

17 I HEREBY CERTIFY, That I attended deceased from 2/16/75, 19 to 4-11-1920, that I last saw him alive on 4/4/20, and that death occurred, on the date stated above, at 4:30 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Diff Nephritis
Mitral Regurg.
Hypertension

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. 14

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) James J. Fay

M. D. 4/11/20 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Green Park

DATE OF BURIAL 4/13 1920

20 UNDERTAKER

M. C. Cook 502 E. North Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital* ST. *15* WARD)REGISTERED NO. *D42171*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *606 Nicoll Lane, Eovans* ST. *15* WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Frederick C. Erhardt Jr.*6 DATE OF BIRTH (month, day, and year) *April 12, 1920*7 AGE Years Months Days If LESS than 1 day, 2 hrs. or min. *X X X*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*(b) General nature of industry, business, or establishment in which employed (or employer) *None*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.* (State or country)10 NAME OF FATHER *Fred C. Erhardt*11 BIRTHPLACE OF FATHER (city or town) *Balto Md.* (State or country)12 MAIDEN NAME OF MOTHER *Mary Otis*13 BIRTHPLACE OF MOTHER (city or town) *N. Y.* (State or country)14 Informant *Frederick C. Erhardt* (Address) *606 Nicoll Lane*15 Filed *APR 13 1920* *ROBERT E. KRAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 11 1920*17 I HEREBY CERTIFY, That I attended deceased from *April 10*, 1920, to *April 11*, 1920, that I last saw him *dead* on *April 11*, 1920, and that death occurred, on the date stated above, at *1:20 a.m.*

The CAUSE OF DEATH* was as follows:

Stelektasis(duration) yrs. mos. *24* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis: *Physical signs*(Signed) *J. B. Bronnshas* M. D.4-11, 1920 (Address) *St Joseph's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral

DATE OF BURIAL

April 14 1920

20 UNDERTAKER

William Cook

ADDRESS

202 E. North

TION is very important. See instructions on back of certificates.

D42172

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42172

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *St Joseph's Hospital* ST. *27* WARD)2-FULL NAME *Mary Erhardt*(a) RESIDENCE. NO. *606 Nicoll Lane, Gorman* ST. *5* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *5* yrs. *5* mos. *5* ds.How long in U. S., if of foreign birth? *5* yrs. *5* mos. *5* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>married</i>
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5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of *Frederick C. Erhardt*6 DATE OF BIRTH (month, day, and year) *Nov 26/1897*

7 AGE <i>22</i>	Years <i>4</i>	Months <i>15</i>	Days <i>15</i>	If LESS than 1 day, hrs. or min.
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8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *Housewife*

(c) Name of employer

9 BIRTHPLACE (city or town) *New York*
(State or country)10 NAME OF FATHER *John E. Otis*11 BIRTHPLACE OF FATHER (city or town) *New York*
(State or country)12 MAIDEN NAME OF MOTHER *Eugenia Hudephane*13 BIRTHPLACE OF MOTHER (city or town) *N. Y.*
(State or country)

14

Informant
(Address)*Frederick C. Erhardt*
606 Nicoll Ave Gorman

15

APR 13 1920

ROBERT A. TRAUTER

Burial Permit *0108*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 11* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

April 10, 19 *20*, to *April 11*, 19 *20*,that I last saw her alive on *April 11*, 19 *20*,and that death occurred, on the date stated above, at *2:20* p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema(duration) yrs. mos. *1* ds.CONTRIBUTORY
(Secondary)*Acute Myocardial Degeneration*(duration) yrs. mos. *5* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date of *4-10-20*Was there an autopsy? *No*What test confirmed diagnosis? *Physical signs*(Signed) *J. B. Bronushas*, M. D.4-11-1920 Address *St Joseph's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral**April 14* 19 *20*

20 UNDERTAKER

William Cook

ADDRESS

502 S. Kent

TION is very important. See instructions on back of certificates.

D42173

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1631 Mosher ST. 16 WARD)

2-FULL NAME

Richard H. Timson

(a) RESIDENCE. NO.

1631 Mosher

(Usual place of abode)
Length of residence in city or town where death occurred 7 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Anne Timson

6 DATE OF BIRTH (month, day, and year)

Aug 12/1849

7 AGE

70

Years

Months

7

Days

29

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Timmont

10 NAME OF FATHER

Leve Timson

11 BIRTHPLACE

FATHER (city or town)

Va

12 MAIDEN NAME OF MOTHER

Mary Tall

13 BIRTHPLACE OF MOTHER (city or town)

Va

14

Informant

Florence Williams

(Address)

1010 W. Franklin

15

Filed

APR 13 1920

ROBERT I. FRANKLIN

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Apr 5, 1920, to Apr 10, 1920;

that I last saw him alive on Apr 5, 1920, and that death occurred, on the date stated above, at 6 P. m.,

The CAUSE OF DEATH* was as follows:

Cardiac debility -

CONTRIBUTORY (Secondary) arterio sclerosis - (duration) yrs. 2 mos. ds. At hemiplegia - (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) M. D. 37 W. Preston St.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wood Lawn Cem. DATE OF BURIAL April 14 1920 ADDRESS 1716 Mo

20 UNDERTAKER

John Cork

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *1322 Union Ave* ST. *13* WARD)2-FULL NAME *Eugene F Hilgeo*(Residence in Baltimore: No. *1322 Union Ave* St., yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Married

6-DATE OF BIRTH,

June 2, 1849

(Month) (Day) (Year)

7-AGE,

*70 yrs. 10 mos. 11 ds.*If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Painter, 50*9-BIRTHPLACE,
(State or Country).*Balto City*

10-NAME OF FATHER,

Philip Hilgeo

11-BIRTHPLACE OF FATHER

(State or Country).

Balto City

12-MAIDEN NAME OF MOTHER

*Sarah Reed*13-BIRTHPLACE OF MOTHER
(State or Country).*Me*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Margaret A Hilgeo

(Address)

1322 Union Ave

15-

APR 13 1920

ROBERT K KRAUTER

Filed

ID1

Burial Firm Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

April 13, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry) and that said deceased came to death *on the day stated above.*

The CAUSE OF DEATH was as follows:

Heart failure

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John H. ... M. D.

(Coroner.)

1920 (Address) *3632 ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St Mary's Hospital**April 15, 1920*

20-UNDERTAKER

ADDRESS

AS Marshall 3539 ...

CASE OF DEATH IN WHICH THIS CERTIFICATE IS IMPORTANT. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42175

D42175

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 E. West St.; 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 313 E. West St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH,

Oct 18

1849

(Month)

(Day)

(Year)

7-AGE,

70

5

mos.

25

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Structure

9-BIRTHPLACE,
(State or Country),

Germany

10-NAME OF FATHER,

H. H. Brant

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

H. H. Brant

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John H. Brant

(Address)

313 E. West St.

15-

ROBERT B. KRAUTER

APR 13 1920

191

Bureau of Health Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April

12

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 10

1920

to April 12

1920

that I saw him alive on April 12

and that death occurred, on the date stated above, at 10 AM

The CAUSE OF DEATH* was as follows:

Pharyngitis, Hemiplegia

(Duration) ... yrs. ... mos. 20 ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis

(Signed)

J. H. Brant

(Address)

1203 E. West St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

April 15, 1920

20-UNDERTAKER

John J. Fidds 1203 E. West St.

D42177

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42173

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *South Baltimore General Hospital* REGISTERED NO. *120*CITY OF BALTIMORE: (No. *19* ST.; *19* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mr. Charles Crowley*(Residence in Baltimore: No. *1714 West Fayette St.* St.; *58* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

m.

4-COLOR OR RACE,

*w.*5-SINGLE, *married*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

March 6, 1879
(Month) (Day) (Year)

7-AGE,

71 yrs. *1* mos. *5* ds.

If LESS than 1 day,

....hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work. *Police Inspector*(b) General nature of industry, business, or establishment in which employed (or employer) *1886*9-BIRTHPLACE,
(State or Country), *Ireland*10-NAME OF FATHER, *Michael Crowley*11-BIRTHPLACE OF FATHER
(State or Country), *Ireland*12-MAIDEN NAME OF MOTHER *Mary Kennedy*13-BIRTHPLACE OF MOTHER
(State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph Crowley**Morris & Noyes Co. Cambridge Mass.*
(Address)

15-

APR 13 1920

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ROBERT H. KRAUTER

Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 11, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *March 18, 1920*, to *April 11, 1920*, that I saw him alive on *April 11, 1920*, and that death occurred, on the date stated above, at *6:30* m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia.

..... (Duration) yrs. mos. ds.

CONTRIBUTORY. *Chronic Interstitial Nephritis.*..... (Secondary) *The latter, 8 hrs.*

..... (Duration) yrs. mos. ds.

(Signed) *Witherburn Fort* M. D.*April 11, 1920* (Address) *1713 Sight St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *24* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral Cem.

DATE OF BURIAL,

April 14, 1920

20-UNDERTAKER

*Wm. J. Hartwell*ADDRESS *25th**Fulton Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42178

CERTIFICATE OF DEATH.

24 D42178
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hospital for Women ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1525 Park Ave. St.; 5 yrs., 1 mos., 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

white5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.) single

6-DATE OF BIRTH.

Mar 5, 1918
(Month) (Day) (Year)

7-AGE.

5 yrs., 1 mos., 6 ds.If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).not any9-BIRTHPLACE.
(State or Country),Baltimore Md

PARENTS.

10-NAME OF FATHER.

Knigman A. Haudy11-BIRTHPLACE OF FATHER
(State or Country).Pa

12-MAIDEN NAME OF MOTHER

Sadie Davis13-BIRTHPLACE OF MOTHER
(State or Country),Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Knigman A. Haudy
1525 Park Ave.

15-

APR 13 1920

ROBERT E. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

April 11, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
April 11, 1920, to April 11, 1920,
that I saw him alive on April 11, 1920,
and that death occurred, on the date stated above, at 11:35 P. m.
The CAUSE OF DEATH* was as follows:Tetanus(Duration).....yrs.....mos.....2 ds.
CONTRIBUTORY (Secondary) Infected wound - 2 days(Duration).....yrs.....mos.....10 ds.
(Signed) George A. Devering M. D.
April 12, 1920 (Address) Womens Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Druid Ridge April 13, 1920

20-UNDERTAKER

ADDRESS

Wm. Mitchell 201 N. Fayette

Charles Workman
HEALTH DEPARTMENT—CITY OF BALTIMORE

D42179

D42179

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1513 W. Gansburgh* ST.: *19* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *1513 W. Gansburgh* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *12* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Husband of May Workman

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

43

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Farmer

9 BIRTHPLACE (city or town) (State or country)

England

10 NAME OF FATHER

I don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

England

12 MAIDEN NAME OF MOTHER

I don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Europe

14

Informant (Address)

John N. Hammel
1513 W. Gansburgh

15

Filed

*APR 3 1920**ROBERT E. KEAUTER**Registrar*
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 11* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

March 11, 19*20*, to *April 10*, 19*20*.that I last saw him alive on *April 10*, 19*20*.and that death occurred, on the date stated above, at *8:30 a m.*

The CAUSE OF DEATH* was as follows:

Edema of Lung

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *chronic interstitial nephritis*

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Examination*(Signed) *Walter A. Coy*, M. D.*413, 1920* (Address) *571 Fulton Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Lawson Park**Apr 13 1920*

20 UNDERTAKER

ADDRESS

*B. T. Turner**1442 N. Del*
may

TION is very important. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D42180

170 D42180

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 2547 Madison Ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Frieda Smith

(Residence in Baltimore: No. 2547 Madison Ave St. 13 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6-DATE OF BIRTH Jan 27, 1873 (Month) (Day) (Year)

7-AGE 47 yrs. 2 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work House Wife (b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE (State or country) Germany

10-NAME OF FATHER Joseph Erlebach

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Nettie Steine

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Smith

(Address) 2547 Madison Ave

15-APR 13 1920

Robert A. Emler Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 4 11, 1920 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from 1910, to 11 1920.

that I saw h. alive on 4-11, 1920.

and that death occurred, on the date stated above, at 4 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 10 yrs. mos. ds.

Contributory (SECONDARY) Alcohol, Diabetes

(Signed) A. J. Barnett M. D.

(Address) 7000 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Baltimore Hebrew

20-UNDERTAKER J. Ahrens & Co

ADDRESS 1611 Madison Ave

DATE OF BURIAL

April 14, 1920

ADDRESS

D42181

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42181

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bay View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 25 WARD)

2-FULL NAME

Felomena Bupat.

(a) RESIDENCE. NO.

807 Curtis Ave,

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

8

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

8

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,

or Divorced (write the word)

Female

White

Married

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

Pete Bupat.

1887.

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

33

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Austria

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Austria

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Austria

14

Informant

(Address)

Bay View Hospital

15

Filed

APR 13 1920

ROBERT I. LAUTER

Registrar

Burial Permit Closed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 12, 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 12, 1920, to

Apr. 12, 1920

that I last saw her alive on

Apr. 12, 1920

and that death occurred, on the date stated above, at

3:20 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminal)

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

Ixc Pyclosis.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

H. Goldsmith, M.D.

4/13/20 Address)

Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

William Falkowski 1618 Eastern Ave.

1042182

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 1042182

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 27)

FULL NAME

Robert J. Klemmer

(Residence in Baltimore: No. 9)

Spring & Glenn A. Belair Road

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Mar 16, 1858

7-AGE

65

25

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Cabinet Maker
0149-BIRTHPLACE.
(State or Country),

Germany

10-NAME OF FATHER,

Jos. Klemmer

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Johanna Seta Schoelzel

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Marion Klemmer

(Address)

Spring & Glenn

15-

Filed

APR 13 1920

191

ROBERT B. KRAUTER

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr 10, 1920

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Insidious (Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. T. Kelly M. D.

Apr 2, 1920 (Address) 1639 Bury

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cemetery

DATE OF BURIAL,

April 14, 1920

20-UNDERTAKER

B. W. Dill

ADDRESS

3109 Fredk. Ave.

important. See instructions on back of certificate.

D42183

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42183

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 598 1/2 Preston ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 598 1/2 Preston St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *col.* 5-SINGLE, *Married*
 MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, *July 11, 1857*
 (Month) (Day) (Year)

7-AGE, *66 yrs. 9 mos. 1 ds.* If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Housewife*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *md.*

10-NAME OF FATHER, *Geo. Waller*
 11-BIRTHPLACE OF FATHER (State or Country), *md.*
 12-MAIDEN NAME OF MOTHER *unknown*
 13-BIRTHPLACE OF MOTHER (State or Country), *✓*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edward Waller*(Address) *Westminster Md.*

15-

Filed *APR 13 1920* 191. *BOBBY R. KRAUTH*
Burial Place

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Apr. 12, 1920*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan. 14, 1920*, to *Apr. 12, 1920*, that I saw her alive on *Apr. 12, 1920*, and that death occurred, on the date stated above, atm.

The CAUSE OF DEATH* was as follows:

Carcinoma of esophagus
diagnosis: X Ray
 (Duration)yrs.mos.ds.

CONTRIBUTORY (Secondary) *Exhaustion*
 (Duration)yrs.mos.ds.

(Signed) *Walter G. Givens* M. D.
Apr. 13, 1920 (Address) *606 Edmondson*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Luke's Cemetery* DATE OF BURIAL, *April 14, 1920*

20-UNDERTAKER *H. B. Elnie* ADDRESS *Academy*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42181

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10, Bleechdale Road

2-FULL NAME J. Harmannus Fisher

(a) RESIDENCE. NO. 10 Bleechdale Road

(Usual place of abode)
Length of residence in city or town where death occurred 35 yrs. 4 mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed,
or Divorced (write the word)

married

5a If married, widowed, or divorced
HUSBAND of

(or) WIFE of

Josephine L. Fisher

6 DATE OF BIRTH (month, day, and year) Dec. 15, 1931

7 AGE 85

Years

Months

Days

If LESS than
1 day, hrs.
or min.

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Banner + Broker 086

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

Baltimore m

9 BIRTHPLACE (city or town)
(State or country)

Baltimore m

10 NAME OF FATHER Wm Fisher

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER Jane Albrecht

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Unknown

14

Informant
(Address)

Frank Fisher

8 Howard Place Guilford Bldg

15 Filed

APR 13 1920

DOREY K. KAUTER

Bureau of Health

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

D42181

ST. 27th WARD

ST. 27th WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth?

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1920

17 I HEREBY CERTIFY, that I attended deceased from
Mar. 20, 1920, to April 12, 1920.

that I last saw him alive on April 11, 1920, at 4-25 A. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:
Left Cerebral Hemiplegia
Senile Arterio-SclerosisCONTRIBUTORY
(Secondary)

Acute Pulmonary

18 Where was disease contracted
if not at place of death?

Place of death

Did an operation precede death?

No

Was there an autopsy?

What test confirmed diagnosis?

Paralysis of Left Side

(Signed)

M. J. Porter

4/12/1920 Address

422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery

Apr 14 1920

20 UNDERTAKER

John B. Spence

1325 N. Camden St

D42186

HEALTH DEPARTMENT CITY OF BALTIMORE

CERTIFICATE OF DEATH

D42186

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.: 1 yrs. 4 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.
or min.?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)9 BIRTHPLACE
(State or country)10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER
(State or country)12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

4 12, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1, 1919, to April 10, 1920

that I saw him alive on April 10, 1920.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis
pernicious

(Duration) yrs. 4 mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Hall M. D.

4-13, 1920 (Address) Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State Life mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

4/14/20

20 UNDERTAKER

ADDRESS

J. L. Liguori & Sons 1000 Pacific

15.

Filed

APR 13 1920

DOCKET & EXAMINER

Baltimore Registrar

N. B.-Every item of information should be carefully classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D42187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

University Hospital

2-FULL NAME

Howard Johnson Jr.

(Residence in Baltimore: No.

613 Delphin St.

REGISTERED No. C

St.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.:

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Single

6-DATE OF BIRTH,

July 28, 1912
Month Day Year

7-AGE,

7 yrs 8 mos 14 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

School.

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

Howard Johnson Jr.
Md.11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

Veronica Holley
Md.13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILED

191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 11, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

and that said deceased came to his death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull. Caused by being
struck by Motor Cycle.
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

as above

(Duration) yrs. mos. ds.

(Signed) H. K. Gorman M. D.

(Coroner.)

4-13-1920 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Cathedral
Bernard L. Wright 1264 Marey

CAUSE OF DEATH in plain terms, so that it may be properly entered. Last statement of deceased, if any, in plain terms, so that it may be properly entered. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42188

D42188

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. Hospital* ST.: *18* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Bessie Lee

(a) RESIDENCE. NO.

477. Carlton

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *4* yrs.

mos.

ds.

How long in U. S., If of foreign birth? *24* yrs. *3* mos. *2* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

*widowed*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*2**Walley*

6 DATE OF BIRTH (month, day, and year)

Jan 3, 1884

7 AGE

36

Years

3

Months

9

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore Md*

10 NAME OF FATHER

*John Nolan*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Glyndon Md*

12 MAIDEN NAME OF MOTHER

*Emily Addison*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Cornell Co. Md*

14

Informant
(Address)*John C. Nolan
477. Carlton St.*

15

*APR 13 1920**ROBERT B. REAUTEK*

Registrar

BALTIMORE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 11*, 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 7, 19*20*, to *Apr. 11*, 19*20*,that I last saw him alive on *Apr. 11*, 19*20*,and that death occurred, on the date stated above, at *2.50 p.m.*

The CAUSE OF DEATH* was as follows:

arterio-sclerosis(duration) *?* yrs. mos. ds.CONTRIBUTORY
(Secondary)*Apoplexy*(duration) yrs. mos. *4* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Lyman S. Abbott*, M. D., 19 (Address) *Franklin Sq. Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Laurel Cemetery**April 4 1920*

20 UNDERTAKER

ADDRESS *114 m**Brown & Telford L. Schrock*

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42189

D42189

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1625 W. Lexington* ST.; *19* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1625 W. Lexington St* St.; *50* yrs., *1* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*Colored*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Married

6-DATE OF BIRTH,

April 10, 1870
(Month) (Day) (Year)

7-AGE,

50 yrs. *1* mos. *1* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, business,
or establishment in which
employed (or employer).....*Laundress*
*841*9-BIRTHPLACE,
(State or Country),10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country),12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George Johnson*(Address) *1625 W. Lexington St.*

15-

APR 13 1920

ROBERT B. BRANTER

Filed *APR 13 1920* 191... *BRANTER* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 11, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
March 29 1920, to *April 11 1920*,
that I saw her alive on *April 10 1920*,
and that death occurred, on the date stated above, at *10 A. m.*

The CAUSE OF DEATH* was as follows:

Apoplexy, Bright Disease
Acute Induration

..... (Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) *Dr. J. M. Howard* M. D.*April 12 1920* (Address) *708 E. ...**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS *114 W. ...*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42190

CERTIFICATE OF DEATH.

D42190

PLACE OF DEATH

CITY OF BALTIMORE (No. 753 Dover St)
 2-FULL NAME Henry Brookhuis
 (Residence in Baltimore: No. 753 Dover St.)

ST: 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single
 (Write the word.)
 6-DATE OF BIRTH, Don't Know, 1870
 (Month) (Day) (Year)

7-AGE, 50 yrs. mos. ds. IF LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work, Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer), 070

9-BIRTHPLACE, (State or Country), MD

10-NAME OF FATHER, Don't Know
 11-BIRTHPLACE OF FATHER (State or Country), Don't Know
 12-MAIDEN NAME OF MOTHER, Don't Know
 13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) Lizzie Spear
 (Address) 812 Maple St.

15- APR 13 1920 ROBERT B. DEBAUTER
 File No. 191 Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 10, 1920
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry. thereon and from the evidence obtained by said Inquest find that said deceased came to his death on the day stated above.
 The CAUSE OF DEATH* was as follows:

Valvular Heart disease
 (Duration) Don't Know yrs. mos. ds.

CONTRIBUTORY Rheumatism
 (Secondary) (Duration) Don't Know yrs. mos. ds.
 (Signed) H. J. Gorman M. D.
 (Coroner)

4.13.1920 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
 At place of death, ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery DATE OF BURIAL, April 13, 1920

20-UNDERTAKER, Mrs. R. Elliott ADDRESS 725

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42191

D42191

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *829 S Milton Ave* ST. *1* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *829 S Milton Ave* St. *30* yrs. *—* mos. *—* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Dec 25, 1867
(Month) (Day) (Year)

7-AGE,

52 4
yrs. mos. ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer)...9-BIRTHPLACE,
(State or Country),*Poland*

10-NAME OF FATHER,

*John Franciszkowski*11-BIRTHPLACE OF FATHER
(State or Country),*Poland*

12-MAIDEN NAME OF MOTHER

*Not Known*13-BIRTHPLACE OF MOTHER
(State or Country),*Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Veronica Franciszkowska

(Address)

829 S Milton Ave

15-

Filed

APR 13 1920

ROBERT E. ELAETER

BRIAN F. B. B. B. B.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 11th, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *March 29, 1920*, to *April 11, 1920*,that I saw him alive on *April 11, 1920*, and that death occurred, on the date stated above, at *4 a. m.*

The CAUSE OF DEATH* was as follows:

*Cerebral Hemorrhage**Abundant* (Duration) yrs. mos. ds.CONTRIBUTORY *Arteriosclerosis*
(Secondary)*Indefinite* (Duration) yrs. mos. ds.(Signed) *John Albert Miller* M. D.*4/13, 1920* (Address) *2777 Eastern Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Poly Robinson

DATE OF BURIAL,

April 14, 1920

20-UNDERTAKER

Stephen Frankowski

ADDRESS

1008 Henric

Important. See instructions on back of certificate.

D42192

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42192

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *110 S. Fifth*ST. *36* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thomas A. Elliott

(a) RESIDENCE. No.

*110 S. Fifth*ST. *26* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *64* yrs. *11* mos. *24* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

late Annie Miller Elliott

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*64**11**24*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

William S. Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country)

U. S.

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

*Joseph A. Elliott**110 S. Fifth St.**Robert P. Harrison,*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-12-20

17

I HEREBY CERTIFY, That I attended deceased from

*April 9, 1920, to April 13, 1920,*that I last saw him alive on *April 13, 1920,*and that death occurred, on the date stated above, at *7 P. M.*

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

unknown

(duration) yrs. mos. ds.

Dilated heart

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

*Wm. J. McCoay, M. D.**4/13, 1920* Address) *1839 S. Ellwood Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mount Carmel Cem.**April 15, 1920*

20 UNDERTAKER

Lilly Gilman

ADDRESS

403 S. Maple St.

CAUSE OF DEATH is printed in plain text so that it may be read by anyone. See instructions on back of certificates.

APR 13 1920

Burial Permit Clerk

D42193

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42193

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Emersonian apt* ST.: *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *Emersonian apt* ST.: *4* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *59* yrs. *10* mos. *22* ds. How long in U. S., if of foreign birth? *12* yrs. *1* mos. *1* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Married</i>
----------------------	---------------------------------	--

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Blanche S. Kamm*6 DATE OF BIRTH (month, day, and year) *May 20 1860*

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<i>59</i>	<i>10</i>	<i>22</i>	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer)

Dept Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Julius Kamm

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Isabelle Hirschman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

*J. Kamm 1327 Eutaw Place**Robert P. Harrison*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 12 1920*

17 I HEREBY CERTIFY, That I attended deceased from

*Nov 12 1919 to April 12 1920*that I last saw him alive on *April 12 1920*and that death occurred, on the date stated above, at *3 A* m.

The CAUSE OF DEATH* was as follows:

Acute pulmonary Oedema

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Atherosclerosis - Myocarditis

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Lois P. Hamburger* M. D.12, 1920 (Address) *1207 Eutaw Place*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Balto Belair April 14 1920

20 UNDERTAKER

ADDRESS

Lois P. Hamburger 1184 W. 7th St

TION is very important. See instructions on back of certificates.

APR 13 1920

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42191

D42191

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1321 West ST.; 9 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 321 West St.; 46 yrs., 1 mos., 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH.

unknown, 1862
(Month) (Day) (Year)

7-AGE.

58

yrs. 1 mos. 1 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Builder

9-BIRTHPLACE.
(State or Country).

Ireland

10-NAME OF FATHER.

Henry Scully

11-BIRTHPLACE OF FATHER
(State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

Ann Conway

13-BIRTHPLACE OF MOTHER
(State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

4 11, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

2/10 1920, to 4-11 1920,that I saw him alive on 4-10 1920,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Universal regurgitation

(Duration) 2 yrs. 1 mos. 1 ds.CONTRIBUTORY
(Secondary)

gumma aneurysm

(Signed) Dr. Bernard W. M. D.4/12 1920 (Address) 914 E. Reddick

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.mos.ds. In the State.....yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Cathedral Cem

DATE OF BURIAL.

4-15, 1920

20-UNDERTAKER

Chas. J. Evans 4501 118th St. Mt Royal Ave.

important. See instructions on back of certificate.

APR 13 1920

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D42195

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42195

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST. 11 WARD)

2-FULL NAME

(a) RESIDENCE. No. 1227 1/2 Charles ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Robert P. Harrison

APR 13 1920

Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 11 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 7, 1920, to April 11, 1920,

that I last saw her alive on April 11, 1920,

and that death occurred, on the date stated above, at eleven A.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? history & birth of son

(Signed) Daniel Miller M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Johns Hopkins Hospital

APR 13 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *886 Booth*)ST.: *18* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lillian Carter

(a) RESIDENCE. NO.

886 Booth

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 *2*

17

I HEREBY CERTIFY, That I attended deceased from

4/10/20, 19 *20*, to *4/12/20*, 19 *20*,that I last saw him alive on *4/12/20*, 19 *20*,and that death occurred, on the date stated above, at *3:30* p. m.

The CAUSE OF DEATH* was as follows:

Chromatolytic (6 1/2 Mo) 45 2 4

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Samuel J. Long*, M. D.*4/12, 1920* (Address) *910 W. L. ...*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*HOPKINS HOSPITAL*19 *20*

20 UNDERTAKER

ADDRESS

APR 13 1920

CAUSE OF DEATH is printed in plain type, so that it may be read by anyone. See instructions on back of certificates.

*APR 13 1920**Samuel J. Long**W. W. WOODBALL*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42197

D42197

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 641 Babory ST.; 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Mae. Jones(Residence in Baltimore: No. 641 Babory St.; 43 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Caucasian5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH,

991877

(Month)

(Day)

(Year)

7-AGE,

43 yrs., mos., ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Domestic070

9-BIRTHPLACE, (State or Country),

Maryland

PARENTS.

10-NAME OF FATHER,

unlabeled

11-BIRTHPLACE OF FATHER (State or Country),

unlabeled

12-MAIDEN NAME OF MOTHER

unlabeled

13-BIRTHPLACE OF MOTHER (State or Country),

unlabeled

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

William C. Harris

(Address)

641 Babory

15-

Robert P. Harrison,

191

Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April11th1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 7 1920, to April 11 1920,that I saw her alive on April 11 1920,and that death occurred, on the date stated above, at 12:45 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....Pulmonary Disease.....

(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....Harry Glassman.....M. D.April 11, 1920. (Address).....26 R. 7 West 4th St......

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mount AuburnApril 13 1920

20-UNDERTAKER

ADDRESS

Charles B. Jones215 Pine St.

Important. See instructions on back of certificate.

D42198

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42198

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5139 Park Heights Ave WARD)

2-FULL NAME

Hannah M. Mallonee

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 5139 Park Heights Ave WARD.

(Usual place of abode)

WARD.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos.

mos.

ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced, (write the word) <u>widow</u>
------------------------	---------------------------------	---

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm L. Mallonee6 DATE OF BIRTH (month, day, and year) Mch. 31. 1847

7 AGE	Years <u>73</u>	Months <u>—</u>	Days <u>13</u>	If LESS than 1 day, hrs. or min.
-------	--------------------	--------------------	-------------------	--

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. Md
(State or country)10 NAME OF FATHER Nicholas Emich11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown12 MAIDEN NAME OF MOTHER Julia W. Foreyich13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown14 Informant Wm Mallonee
(Address) 5139 Park Heights Ave15 Filed Robert F. Harrison,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 13 1920

17

I HEREBY CERTIFY, That I attended deceased from
April 8, 1920, to April 13, 1920.
that last saw her alive on April 13, 1920,
and that death occurred, on the date stated above, at 12 A. m.
The CAUSE OF DEATH* was as follows: Pyemia

(duration) yrs. mos. 4 ds.
CONTRIBUTORY Infected Varicella Virus
(Secondary) Cholera (duration) yrs. mos. 6 ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis Clinical(Signed) James S. Ashurst M. D.(Address) 4012 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Olivet Cem

DATE OF BURIAL

Apr 15 1920

20 UNDERTAKER

Harry W. Ehlen

ADDRESS

184X

TION is very important. See instructions on back of certificates.

APR 13 1920

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42199

HEALTH DEPARTMENT—CITY OF BALTIMORE

150 D42199

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1526 Covington St.

St.: 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David L. Cowan.

(Residence in Baltimore: No. 1526 Covington St.

St.: yrs. 1 mos. -- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single. (Write the word.)

6-DATE OF BIRTH, March 13th, 1920, 1 (Month) (Day) (Year)

7-AGE, 1 yrs. 1 mos. -- ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Ingram H. Cowan. 11-BIRTHPLACE OF FATHER (State or Country), North Carolina. 12-MAIDEN NAME OF MOTHER, Mary Fraley. 13-BIRTHPLACE OF MOTHER (State or Country), North Carolina.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Cowan. (mother)

(Address) 1526 Covington St.

15- Robert P. Harrison, 101 Registrar.

APR 13 1920

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 13th, 1920, 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) And that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Vitral Insufficiency. Congenital. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) Otto M. Reinhardt M. D. April 13 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 10 11

20-UNDERTAKER, ADDRESS 1318 1/2 St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42200

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 18 WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

82 yrs. 4 mos. 20 ds.

How long in U. S., if of foreign birth?

82 yrs. 4 mos. 20 ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(Resident)

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

George C. Irlan

6 DATE OF BIRTH (month, day, and year)

Nov-23-1837

7 AGE

82

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Frederick Achey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Litz Penna

12 MAIDEN NAME OF MOTHER

Margaret Garrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

not known Virginia

14

Informant (Address)

Edwin C. Irlan (Son) 518 N. Arlington Ave

APR 13 1920

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 12 1920

17

I HEREBY CERTIFY, That I attended deceased from for several years, to Apr. 12, 1920.

that I last saw her alive on Apr. 12, 1920.

and that death occurred, on the date stated above, at 4 P.m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Swine Dysentery

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) W. B. Rider M. D.

, 19 (Address) 887 Harbor Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

McElvett Cemetery

Apr. 15 1920

20 UNDERTAKER

STEWART & MOWEN COMPANY

ADDRESS

(WILLIAM F. WOODEN, Successor)

108 W. NORTH AVE.

Burial Permit Clerk.

TION is very important. See instructions on back of certificates.

D42201

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42201

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 Cumberland Place St. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clepton Thompson(a) RESIDENCE. NO. 713 Cumberland St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant
(Address)

15

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

April 20, 1920, to April 13, 1920,

that I last saw him alive on April 11, 1920,

and that death occurred, on the date stated above, at 20 m.

The CAUSE OF DEATH* was as follows:

Bronchitis Pneumonia
(Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Head (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Carpenter, M. D.12, 1920 (Address) 1504 M. G. Gullough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Wylshireville Md 4/15/20

20 UNDERTAKER

ADDRESS

Edwin Ringgold 4463 Carey

TION is very important. See instructions on back of certificates.

PRI 13 1920

Burial Permit Clark

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42202

D42202

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 Madison Ave. ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elizabeth Rodger Greig

(a) RESIDENCE

No. 2000 Madison Ave. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

William Greig

6 DATE OF BIRTH (month, day, and year)

Nov 25th 1839

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

80

4

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Glasgow Scotland

10 NAME OF FATHER

James Rodger

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Glasgow Scotland

12 MAIDEN NAME OF MOTHER

Elizabeth McGowan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Glasgow Scotland

14

Informant (Address)

Margaret R. Greig 2000 Madison Ave

15

Filed

APR 4 1920

ROBERT B. KRAUTH

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 12 1920

17

I HEREBY CERTIFY, That I attended deceased from

Feb 17 1917 to April 11 1920 that I last saw him alive on April 11 1920

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Atherosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Fisher, M. D.

19 (Address) 1008 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cem

4/14/20

20 UNDERTAKER

ADDRESS

Wm. Tucker & Son N. & Pa

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johna Hopkins Hosp.* ST.: *7* WARD)REGISTERED NO. *91-07*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. *Leon Young*(a) RESIDENCE. NO. *615 N. Bond St.* ST.: *12th* WARD. *12th*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Child*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Child*6 DATE OF BIRTH (month, day, and year) *Sept 5-1919*7 AGE Years *7* Months *7* Days *7* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.* (State or country)10 NAME OF FATHER *Wm. Jackson*11 BIRTHPLACE OF FATHER (city or town) *Md.* (State or country)12 MAIDEN NAME OF MOTHER *Hazel Young*13 BIRTHPLACE OF MOTHER (city or town) *N. J.* (State or country)14 Informant *Hospital Record* (Address)15 *APR 14 1920* *ROBERT A. KAUFER* Registrar *Barial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 12 1920*17 I HEREBY CERTIFY, That I attended deceased from *April 9*, 1920, to *April 12*, 1920, that I last saw him alive on *April 12*, 1920, and that death occurred, on the date stated above, at *6:30 P.* m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *3*(duration) yrs. mos. ds. *3*18 Where was disease contracted if not at place of death? *Patent Home*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Clinical + autopsy* (Signed) *Wm. H. Hays* M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS *1502**John W. Henderson**E. monument*

TION is very important. See instructions on back of certificates.

D42204

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42204

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Jordan(a) RESIDENCE. No. 1412 E. Lexington St. ST. 5 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18997 AGE Years 21 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER James Cook11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Annie Taylor13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant Hospital Records (Address) M.T.H.15 APR 14 1920 ROBERT E. HARTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12, 192017 I HEREBY CERTIFY, That I attended deceased from April 6, 1920, to April 12, 1920, that I last saw h. er alive on April 12, 1920, and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum(Signed) George A. Wilkinson, M. D.4-12-20 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Marley Rock Church Cemetery
a a Co. Md

DATE OF BURIAL

APR 14 1920

20 UNDERTAKER

JOHN F. DENNY

ADDRESS

715 LIGHT ST.

TION is very important. See instructions on back of certificates.

Wedi
HEALTH DEPARTMENT—CITY OF BALTIMORE

D42205

CERTIFICATE OF DEATH.

28 D42205

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *431 Fulton Ave* ST.: *19* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *431 Fulton Ave*

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

APR 14 1920

ROBERT A. LEADY

Registrar

Social Permit 0101

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb 1, 1920, to *April 12*, 1920,that I last saw him alive on *April 12*, 1920,and that death occurred, on the date stated above, at *11:30 a.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Walter A. Cox*, M. D.413 1920 (Address) *541 Fulton Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

TION is very important. See instructions on back of certificates.

D42206

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D42206

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 726 E. Biddle St.

ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerome W. Turner.

(a) RESIDENCE. NO. 726 E. Biddle

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

3 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 29, 1893

7 AGE	Years	Months	Days	If LESS than 1 day. hrs.	or min.
27	2	14			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electric Work, 029

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gas & Electric Co.

9 BIRTHPLACE (city or town)
(State or country) Maryland,

10 NAME OF FATHER Samuel Turner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary L. Lloyd.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Sadie Turner.

(Address) 726 E. Biddle St.

15 APR 14 1920 ROBERT A. KAUTEN
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan Nov 1919, to Apr 13 1920, that I last saw him alive on Apr 12 1920.

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Tubercular peritonitis

(duration) 5 yrs. 5 mos. ds.

CONTRIBUTORY Toxemia

(Secondary) in pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 25, 1920

Was there an autopsy? No

What test confirmed diagnosis? Gross pathology

(Signed) E. H. Hayward, M. D.

14 1920 (Address) 2310 Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St Marys Cemetery Md 4/15 1920

20 UNDERTAKER

ADDRESS

Chas. F. Evans & Son 118 W. Mt Royal Ave

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42207

CERTIFICATE OF DEATH.

79
13
REGISTERED NO. C

D42207

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 Powers ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes C. Holt(Residence in Baltimore: No. 822 Powers St.; 8 yrs., 8 mos., 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH,

July 21, 1897
(Month) (Day) (Year)

7-AGE,

52 yrs., 8 mos., 22 ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. nurse
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Va.

10-NAME OF FATHER,

Ho. Boyer

11-BIRTHPLACE OF FATHER (State or Country),

Va

12-MAIDEN NAME OF MOTHER

Eliz. Barber

13-BIRTHPLACE OF MOTHER (State or Country),

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss J. J. J.(Address) 822 Powers

15-

Filed APR 14 1920

ROBERT A. KRAUTH

Burial Pass (Reg. 100-1)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

April 12, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 1, 1919, to April 12, 1920, that I saw her alive on April 11, 1920, and that death occurred, on the date stated above, at 89 m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
(Duration) 9 yrs., 9 mos., 9 ds.

CONTRIBUTORY (Secondary)

(Signed) Chas. F. Coughlin M. D.
412, 101 (Address) 37 St. R. 101

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 8 yrs., 8 mos., 8 ds. In the State 8 yrs., 8 mos., 8 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Mary's Hospital April 12, 1920

20-UNDERTAKER

ADDRESS

Ed. Roy Stipp 125 E. North

D42208

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42208

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Lewis(a) RESIDENCE. No. 1828 Division St ST. 17 WARD.(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) ✓5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓6 DATE OF BIRTH (month, day, and year) Apr. 13, 19207 AGE Years Months Days If LESS than 1 day, 1 hrs. or 5 min. ✓

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓(b) General nature of industry, business, or establishment in which employed (or employer) ✓(c) Name of employer ✓9 BIRTHPLACE (city or town) md
(State or country)10 NAME OF FATHER Henora Lewis11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)12 MAIDEN NAME OF MOTHER Bunnie Wright13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)14 Informant W. W. G. W.
(Address) Johns Hopkins Hospital15 APR 4 1920 ROBERT I. BAUTEN
Registrar
Social Hygiene Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 13, 192017 I HEREBY CERTIFY, That I attended deceased from Apr. 13, 1920, to Apr. 13, 1920, that I last saw him alive on Apr. 13, 1920, and that death occurred, on the date stated above, at 120 p.m.

The CAUSE OF DEATH* was as follows:

Intrauterine Asphyxia,
(duration) — yrs. — mos. — ds.CONTRIBUTORY
(Secondary)(duration) — yrs. — mos. — ds.18 Where was disease contracted
If not at place of death?Did an operation precede death? — Date of —Was there an autopsy? —

What test confirmed diagnosis?

(Signed) John W. Harris, M. D.#13 1920 Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt AuburnApr 14 1920

20 UNDERTAKER

ADDRESS

Sam. W. Chase - m1400 N. K. St

TION is very important. See instructions on back of certificates.

D42209

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42209

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 441 E. 27th St. ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen May Jones(a) RESIDENCE. No. 441 E. 27th St. ST.: 12 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofEdward Jones6 DATE OF BIRTH (month, day, and year) April 5-18847 AGE 66 Years Months Days 8 If LESS than
t day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md10 NAME OF FATHER Thomas Hardesty11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md12 MAIDEN NAME OF MOTHER May Kimball13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14

Informant Mabel J. Galt
(Address) 351 Highland Ave

15

Filed

APR 14 1920

BUREAU OF HEALTH

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13/20 1917 I HEREBY CERTIFY, That I attended deceased from
March 15, 1920, to April 13, 1920,
that I last saw her alive on April 12, 1920
and that death occurred, on the date stated above, at 1-70 m.

The CAUSE OF DEATH* was as follows:

Exhaustion Syncope(duration) yrs. mos. 3 ds.CONTRIBUTORY
(Secondary)(duration) yrs. 10 mos. — ds.18 Where was disease contracted
If not at place of death?Did an operation precede death? No Date of ✓Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. J. H. Hensley

M. D.

4/13, 1920 Address 602 E. 27th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Landon Park4/16 1920

20 UNDERTAKER

ADDRESS

Wm Cook219 N. Mt.

CAUSE OF DEATH is very important. See instructions on back of certificates.

D42210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH.

CITY OF BALTIMORE: (No. 4425 E. Pennsylvania Ave ST.: 70 WARD)

2-FULL NAME

Samuel Graham

(a) RESIDENCE. NO.

4425 E. Pennsylvania Ave ST.: 70 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds.

(If nonresident give city or town and State)

How long in U. S., If of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary E. Graham

6 DATE OF BIRTH (month, day, and year)

Dec 21 1843

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

76

3

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Mrs. Jennie Treachel 4425 E. Pennsylvania Ave

15

APR 14 1920

ROBERT A. KRAUTH

Registrar

Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1920

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1920, to April 12, 1920, that I last saw him alive on April 12, 1920, and that death occurred, on the date stated above, at 9:35 a.m.

The CAUSE OF DEATH was as follows: Chronic Interstitial Nephritis

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. B. West, M. D.

#13, 1920 (Address) 5600 York Rd. Balt. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Md April 10 1920

20 UNDERTAKER

Wm. L. Brown & Co.

HEALTH DEPARTMENT - CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42211
1-PLACE OF DEATHCITY OF BALTIMORE: (No. 2304 E FederalST.: 8 WARD)6-091
REGISTERED D42211

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin Jerome Skuhr(Residence in Baltimore: No. 2304 E FederalSt.: Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, Married,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, Oct 3, 1915
(Month) (Day) (Year)7-AGE, 4 yrs. 6 mos. 9 ds. If LESS than 1 day,
.... hrs. or min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Child
(b) General nature of industry, business, or establishment in which employed (or employer) no9-BIRTHPLACE, (State or Country), Balt City10-NAME OF FATHER, Peter J Skuhr11-BIRTHPLACE OF FATHER (State or Country), MS.12-MAIDEN NAME OF MOTHER Ruthy Lemley13-BIRTHPLACE OF MOTHER (State or Country), MS.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Skuhr(Address) 2304 E Federal St.15- APR 14 1920

Filed..... 191.....

ROBERT F. KEAUTER

Burial Permitted

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 12, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
4-10 1920, to 4-12 1920,
that I saw him alive on 4-12 1920,
and that death occurred, on the date stated above, at 9:30 p.m.
The CAUSE OF DEATH* was as follows:Pneumonia
(Duration) yrs. mos. 3 ds.CONTRIBUTORY Measles
(Secondary) (Duration) yrs. mos. 14 ds.(Signed) Elijah L. Russell M. D.
4-13, 1920 (Address) 101 N. Milton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore DATE OF BURIAL, April 15, 192020-UNDERTAKER William Cook ADDRESS 502 E. North Ave.

important. See instructions on back of certificate.

D42212

HEALTH DEPARTMENT—CITY OF BALTIMORE D42212

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1620 Abbott* ST.: *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *James J. Nosek*(a) RESIDENCE. NO. *1620 Abbott* ST.: _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 26, 1894*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*25**9**18*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shipping clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

Drug shop

(c) Name of employer

Frank & Son

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*10 NAME OF FATHER *Gayton Nosek*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Bohemia*12 MAIDEN NAME OF MOTHER *Mary Proufal*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md.

14

Informant (Address)

1620 Abbott St. Mary Nosek

15

Filed

APR 14 1920

ROBERT A. KAUFER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 14* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

March, 19 *20*, to *April 13*, 19 *20*.that I last saw him alive on *April 13*, 19 *20*.and that death occurred, on the date stated above, at *1:30 A.* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) *3* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) *Frank J. Ayer*, M. D.19 (Address) *2005 E. Monument St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Most Holy Redeemer**April 17 1920*

20 UNDERTAKER

*Ginkler & Ginkler*ADDRESS *734**Eager*

TUTION is very important. See instructions on back of certificates.

D42213

HEALTH DEPARTMENT—CITY OF BALTIMORE, D42213

CERTIFICATE OF DEATH.

PLACE OF DEATH

Mercy Hospital

CITY OF BALTIMORE (No.

1730 St Paul St

ST.

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Ignatius Pike Gough

(Residence in Baltimore: No.

1730 St Paul St

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Married

6-DATE OF BIRTH,

May 29, 1849
(Month) (Day) (Year)

7-AGE,

70 yrs. 10 mos. 15 ds.

If LESS than 1 day,

...hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

St Marys Co Md

10-NAME OF FATHER,

Edward Gough

11-BIRTHPLACE OF FATHER
(State or Country),

St Marys Co Md

12-MAIDEN NAME OF MOTHER

Martha Pine

13-BIRTHPLACE OF MOTHER
(State or Country),

St Marys Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Fannie Gough

(Address)

1730 St Paul St

15-

APR 14 1920

101.

ROBERT L. KAUTER

Baltimore

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 13th, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an...
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said...
(Inquest, au-

topsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Autopsy showed...
...
...
(Duration) ... yrs. ... mos. ... ds.CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.
(Coroner.)

Apr 13, 1920 (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place ... In the
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cable Street St Marys Co Md ... 14 1920

20-UNDERTAKER

ADDRESS Orchard

Henry J. Jenkins, Son Co McCallister St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D42214

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42214

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 Orleans ST.:

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1629 Orleans ST.,

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs.

mos.

ds.

How long in U. S., If of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Albert H. Schreiber

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66

4

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

John H. Schreiber

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Ellen Schreiber

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Albert Schreiber
1629 Orleans St.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 12 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 4, 1920, to April 12, 1920,

that I last saw him alive on April 12, 1920,

and that death occurred, on the date stated above, at 11:45 P. M.

The CAUSE OF DEATH* was as follows:

Acute lobes

Pneumonia

CONTRIBUTORY (Secondary)

Acute Gastric Enteritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

John J. Fitch, M. D.

*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn Cem

DATE OF BURIAL

Apr 15 1920

20 UNDERTAKER

J. Schreiber

ADDRESS

2008 Orleans

CAUTION is very important. See instructions on back of certificates.

APR 14 1920

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42215

D42215

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 S Port St. ST.; 1 WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

709 S. Port St.; yrs., mos., 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

April 10, 1920
(Month) (Day) (Year)

7-AGE,

3 yrs., mos., ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None" "

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Mary Adamczyk

13-BIRTHPLACE OF MOTHER (State or Country),

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Josephine Lamparsky
709 S. port St

15-

Filed

APR 14 1920

Robert P. Harrison,

Burial Permit clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 10 1920, to April 14 1920,that I saw him alive on April 14 1920,and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Congenital debility(Duration)....yrs....mos....3..ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed)

Frank Adamczyk M. D.
April 14, 1920. (Address) 2431 Fair

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Rosary April 14, 1920

20-UNDERTAKER

ADDRESS

William Halkowski 168 Eastern Ave

important. See instructions on back of certificate.

D42216

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42216

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1015 N. Caroline St.* ST.; *7* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1015 N. Caroline St.* St.; *73* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE, *married*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Nov. 11, 1845
(Month) (Day) (Year)

7-AGE,

74 yrs. *5* mos. *2* ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired
*Tailor*9-BIRTHPLACE,
(State or Country).*Germany*

10-NAME OF FATHER,

*Jos. Hallameyer*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Anne Hantz*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Anne B. Hallameyer (wife)*(Address) *1015 N. Caroline St.*

15-

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 13, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 8th 1919, to *April 13th 1920*,that I saw him alive on *April 13*, 1920,and that death occurred, on the date stated above, at *7:30 P. m.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)*Arterio-sclerosis (Mural)*

(Duration) ... yrs. ... mos. ... ds.

(Signed)

J. J. Seab M. D.*April 14, 1920* (Address) *1015 N. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Cemetery

DATE OF BURIAL,

Apr. 16, 1920

20-UNDERTAKER

Henry Hock Son

ADDRESS

301 E. Eager St.

important. See instructions on back of certificate.

APR 14 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42218

CERTIFICATE OF DEATH.

152 D42218
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 Saratoga St ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. Baby "Pratono" 618 Saratoga St St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Infant
(Write the word.)6-DATE OF BIRTH. April 14, 1920
(Month) (Day) (Year)7-AGE. Infant If LESS than 1 day, yrs. mos. ds. ...hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Infant
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),Baltimore

10-NAME OF FATHER,

Pasquale Pratono11-BIRTHPLACE OF FATHER
(State or Country),Italy

12-MAIDEN NAME OF MOTHER

Maria Chedivier13-BIRTHPLACE OF MOTHER
(State or Country),Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pasquale Pratono(Address) 618 Saratoga St

15-

APR 14 1920 Robert P. Harrison,
191Burial Permit Register.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH April 14, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 14 1920, to April 14 1920, that I saw h alive on 191 and that death occurred, on the date stated above, at 10:45 m.

The CAUSE OF DEATH* was as follows:

Faulty presentation in labor - Transverse - difficult delivery
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Joseph L. Valentin M. D.April 14, 1920 (Address) 16 S. Maryland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

D42219 HEALTH DEPARTMENT—CITY OF BALTIMORE

D42219

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.: *13* WARD)

2-FULL NAME

Baby Ritenour

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

2053 West Woodberry Ave.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 10, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, 3 hrs. or 75 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Stewart Ritenour

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Stemmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md.

14

Informant (Address)

Hospital Records, University Hospital

15

Filed

*APR 14 1920**Robert P. Harriman,*

Registrar

Death Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 10 1920

17

I HEREBY CERTIFY, That I attended deceased from

*April 10, 1920, to April 10, 1920,*that I last saw her alive on *April 10, 1920,*and that death occurred, on the date stated above, at *6.30 P. m.*

The CAUSE OF DEATH* was as follows:

Asphyxia neonatorum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. A. Buchness*, M. D., 19 (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITAL

19

20 UNDERTAKER

ADDRESS

*Cornelius R. Routh,**Reg. W. E. WOODALL**APR 14 1920*

CAUSE OF DEATH in plain terms, so that it may be properly certified. See instructions on back of certificates.

D42220

Spec.—6-9-19—H. P. Co.—1000 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42220

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Moore

(a) RESIDENCE. NO. Unknown
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE

Years

Months

Days

67

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work Laborer(b) General nature of industry,
business, or establishment in
which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14

Informant Hospital Records
(Address) New City Hospital

15

Filed Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 2, 1918, to April 9, 1920,

that I last saw him alive on April 9, 1920,

and that death occurred, on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) J. H. Harrison, M. D.

4-9-1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL.

20 UNDERTAKER

Comm. Under Health,
Per. Wm. E. WOODALL.

ADDRESS

APR 14 1920

CAUSE OF DEATH in plain terms, so that it may be understood by persons not familiar with medical terms. See instructions on back of certificates.

D42221

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42231

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital.ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Peterson(a) RESIDENCE. NO. Unknown
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

ST. WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black5 Single, Married, Widowed,
or Divorced (write the word)
Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1875

7 AGE

45

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workDomestic(b) General nature of industry,
business, or establishment in
which employed (or employer)Unknown

(c) Name of employer

Unknown9 BIRTHPLACE (city or town)
(State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown14 Informant Hospital Records

(Address)

New City Hospital.

15 Filed

19

Robert F. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 192017 I HEREBY CERTIFY, That I attended deceased from
April 30., 1914, to April 9, 1920.that I last saw her alive on April 9, 1920.and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosisCONTRIBUTORY (duration) — yrs. — mos. 2 ds.
Arterio-sclerosis
(Secondary) (duration) ? yrs. — mos. — ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No special test(Signed) W. H. Herman, M. D.19 PLACE OF BURIAL, CREMATION OR REMOVAL
(Address) New City Hospital.*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Woodall's Health,
Per Wm E. WOODALLAPR 14 1920

CAUSE OF DEATH is very important. See instructions on back of certificates.

APR 14 1920

Burial Permit Clerk.

D42222

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42222

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Stewart(a) RESIDENCE. NO. 503 W. Lombard St. ST. 4 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Cora Stewart6 DATE OF BIRTH (month, day, and year) 18717 AGE Years 49 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland10 NAME OF FATHER John N. Stewart11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland12 MAIDEN NAME OF MOTHER Mary Stewart13 BIRTHPLACE OF MOTHER (city or town) Annapolis (State or country) Maryland14 Informant Hospital Records (Address) M.T.H.15 Filed Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12, 1920

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1920, to April 12, 1920,that I last saw him alive on April 11, 1920,and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum(Signed) George K. Wilkeson M. D.4-12-20 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

19

20 UNDERTAKER

Cremationer Health.

ADDRESS

APR 14 1920APR 14 1920

Burial Permit Clerk.

CAUSE OF DEATH is very important. See instructions on back of certificates.

D42223

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42223

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *9 Brehm's Lane* ST.: *8* WARD)

2-FULL NAME

John A. Hetherick

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

9 Brehm's Lane

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 9th 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*5**5*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

John Hetherick

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Maryland

12 MAIDEN NAME OF MOTHER

Maisy Farrar

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Maryland

14

Informant (Address)

*John Hetherick 9 Brehm's Lane**Robert P. Harrison,*

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 14th 1920

17

I HEREBY CERTIFY, That I attended deceased from *April 13th 1920* to *April 14th 1920* that I last saw him alive on *April 14th 1920* and that death occurred, on the date stated above, at *443rd* m.

The CAUSE OF DEATH* was as follows:

Acute Enteric Catarrh

CONTRIBUTORY (Secondary)

Calculus yrs. mos. ds. *1*

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signature) *W. O. Stone* M. D.Address) *1504 C. E. Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Jerusalem Cemetery**April 17 1920*

20 UNDERTAKER

Frank Lessard & Co

ADDRESS

Baltimore Md

TUTION is very important. See instructions on back of certificates.

APR 14 1920

D42224

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42224

1-PLACE OF DEATH

Bay View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 26 WARD)

2-FULL NAME

Henrietta Hurley

(a) RESIDENCE. No.

Modlin & Linder Arts. Overlea.

(Usual place of abode)

Unknown.

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

Unknown.

6 DATE OF BIRTH (month, day, and year)

1856

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

64

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

Housework.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Unknown Virginia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Do.

14

Informant (Address)

Bay View Hospital Baltimore, Md.

15

File

Robert P. Harrison,

Registrar

APR 4 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 12, 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 2, 1920 to April 12, 1920.

that I last saw her alive on Apr. 12, 1920.

and that death occurred, on the date stated above, at 1:45 p.m.

The CAUSE OF DEATH* was as follows:

Acute Purulent meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Inte Delirium

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

Pneumonia

(Signed)

H. Goldsmith M. D.

4/12/20 Address)

Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

April 15, 1920

20 UNDERTAKER

ADDRESS

Thek Lassar & Sons

Baltimore

D42225

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42225

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *231 President* ST.: *3* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John Ader

(a) RESIDENCE. NO.

231 President

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. *8* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April 5th. 1920*

7 AGE

— Years

— Months

8 Days

If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

City

10 NAME OF FATHER

Frank Ader

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Annie Shotenider

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Father Frank Ader 231 President St.

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 13th* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

*April 11th. 1920, to April 13th. 1920,*that I last saw him alive on *April 12th. 1920,*and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH* was as follows:

Premature birth; child refused food due to general debility.(duration) — yrs. — mos. *8* ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) *Samuel Snyder* M. D., 19 (Address) *29 So. Caroline St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Sacred Heart Cem**APR 15 1920*

20 UNDERTAKER

ADDRESS

*E. J. Tink & Son,**Funeral Directors & Embalmers 811 N. Wolfe*

APR 14 1920

D42226

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42226

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1116 Hubbard* ST.; *24* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1116 Hubbard* St.; *75* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widower*

6-DATE OF BIRTH,

April *13*, *1845*
(Month) (Day) (Year)

7-AGE,

75 yrs. mos. ds.If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Retired*9-BIRTHPLACE,
(State or Country),*Baltimore City*

10-NAME OF FATHER,

*Henry Dixon*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore City*

12-MAIDEN NAME OF MOTHER

*not given*13-BIRTHPLACE OF MOTHER
(State or Country),*not given*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Chamberlain*(Address) *1116 Hubbard St.*

15-

Robert P. Harrison,
191.....

APR 14 1920 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April *13*, *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 12 191*20* to *April 13* 191*20*that I saw him alive on *April 12* 191*20*and that death occurred, on the date stated above, at *9 P.* m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (Interstital)
Pseudo-carditis

(Duration) yrs. mos. ds.

CONTRIBUTORY. *Heart Failure*
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *F. S. Thompson* M. D.*April 14*, 191*20* (Address) *423 E. Fort*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Trinity Cemetery

DATE OF BURIAL,

April 15, 1920

20-UNDERTAKER

Cro. M. Fink & Son,

ADDRESS

811 N. Wolfe St.

Persons' Directors & Embalmers.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42227

CERTIFICATE OF DEATH.

92 D42227

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 2 Edwood Ave. 1 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 13 2 Edwood Ave. St.: 6 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Child
(Write the word.)

6-DATE OF BIRTH,

Aug 16, 1919
(Month) (Day) (Year)

7-AGE,

8 yrs. 8 mos. 25 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Faltzer(Address) 3 S. Edwood Ave

15-

Filed

APR 14 1920

Robert P. Harrison

191

Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 14, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

4/4/20 191, to 4/14/20 191that I saw her alive on 4/14/20 191and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia..... (Duration)..... yrs..... mos. 10 ds.CONTRIBUTORY
(Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) Frederick Harrison M. D.4/14/20, 191. (Address) 2919 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

April 14 1920

20-UNDERTAKER

Edmund W. Conklin 924 E. Eager

ADDRESS

101

important. See instructions on back of certificate.

D42228

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42228

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1304 Union Ave. ST.: 13 WARD)

2-FULL NAME

Harry H. Little

(a) RESIDENCE. No.

1304 Union Ave

ST.: 13 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary C. Little

6 DATE OF BIRTH (month, day, and year) Sept. 8-1882

7 AGE Years 37 Months 7 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr. Vernon, Woodberry Mills.

9 BIRTHPLACE (city or town) Carroll Co. (State or country) Maryland.

10 NAME OF FATHER Jm. H. Little

11 BIRTHPLACE OF FATHER (city or town) Carroll Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Susanna Spingling

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co. (State or country) Md.

14 Informant Mrs. Catherine Barth (Address) 1304 Union Ave

15 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13, 1920

17 I HEREBY CERTIFY, That I attended deceased from

1917, to Apr. 13, 1920

that I last saw him alive on Apr. 13, 1920

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of chest

(Signed) A. J. Davies, M. D.

(Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Mary's Hampden April 15, 1920

UNDERTAKER Horace Burgee & Son ADDRESS 363 Hall St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 14 1920

Burial Permit Clerk.

D42229

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42229

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 E. Chase ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Anna Restivo(Residence in Baltimore: No. 1608 E. Chase St. 18 yrs., 1 mos., 12 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)
Widow

6-DATE OF BIRTH.

March 2, 1849
(Month) (Day) (Year)

7-AGE.

71 yrs., 1 mos., 12 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),
Italy

10-NAME OF FATHER

Carmelo Caporaso11-BIRTHPLACE OF FATHER
(State or Country),
Italy

12-MAIDEN NAME OF MOTHER

Maria Fiorini13-BIRTHPLACE OF MOTHER
(State or Country),
Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Angela Restivo(Address) 1608 E. Chase St

15-

APR 14 1920 Robert P. Harrison,
Filed

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

April 14, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
April 9- 1920, to April 14 1920,
that I saw her alive on April 13- 1920,
and that death occurred, on the date stated above, at 5 a. m.
The CAUSE OF DEATH* was as follows:

The CAUSE OF DEATH* was as follows:

Myocarditis(Duration) 7 yrs., 1 mos., 12 ds.CONTRIBUTORY
(Secondary)(Duration) 10 yrs., 10 mos., 10 ds.(Signed) Kenyon S. Pessagno M. D.April 14, 1920, (Address) 2314 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 yrs., 1 mos., 12 ds. In the State 18 yrs., 1 mos., 12 ds.Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL.

St. Vincent Cem.

DATE OF BURIAL.

4/16/20, 191...

20-UNDERTAKER

Geo. J. Ruth

ADDRESS

1735 - Howard

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42230

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42230

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

Union Prot. Inf. St. 27

WARD)

2-FULL NAME

Charles B. Russell

(Residence in Baltimore: No.

5301 1/2 Reisterstown Rd

St.;

yrs. 1

mos.

ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
married

6-DATE OF BIRTH,

March 15, 1888
(Month) (Day) (Year)

7-AGE,

31 yrs. 0 mos. 29 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Capt. Bld. Const. Construction

9-BIRTHPLACE, (State or Country),

Pa

10-NAME OF FATHER,

Thos. A. Russell

11-BIRTHPLACE OF FATHER (State or Country),

Pa

12-MAIDEN NAME OF MOTHER

Emilia J. Payne

13-BIRTHPLACE OF MOTHER (State or Country),

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Stanislaw Russell

(Address)

2730 N. Calvert St

15-

Robert P. Harrison,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr. 13, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Kidney in automobile struck by a street car. Fracture of ribs.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Internal Hemorrhage

(Signed) J. E. Smith

(Coroner.)

101... (Address) 101 E. 11th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL,

Druid Ridge

DATE OF BURIAL,

April 14, 1920

20-UNDERTAKER

John O'Connell

ADDRESS

1201 N. Taylor St

APR 14 1920

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42231

CERTIFICATE OF DEATH.

D42231
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. *1332 Division* ST. *17* WARD)

2-FULL NAME

Isaiah Blackwell

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. *1332 Division* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *3* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *colored* 5 Single, Married, Widowed, or Divorced (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1897*7 AGE *23* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Porter*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Mr. Norr*9 BIRTHPLACE (city or town) *Northumberland Va* (State or country)10 NAME OF FATHER *Leharlo Blackwell*11 BIRTHPLACE OF FATHER (city or town) *Northumberland Va* (State or country)12 MAIDEN NAME OF MOTHER *Julia Duggs*13 BIRTHPLACE OF MOTHER (city or town) *Northumberland Va* (State or country)14 Informant *Julia Blackwell* (Address) *1332 Division St*15 *APR 15 1920* *ROBERT B LAUTER* Registrar Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 17 1920*17 I HEREBY CERTIFY, That I attended deceased from *April 6th 1920* to *April 11th 1920*, that I last saw him alive on *April 11th 1920*, and that death occurred, on the date stated above, at *8:30 P.M.*

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia(duration) yrs. mos. ds. *7*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *2*18 Where was disease contracted if not at place of death? *at employment*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *inspiration Percussion*(Signed) *Geo. H. Lauterbach* M. D.4-12-1920 Address) *2215 W. North Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*int Auburn**April 1920*

20 UNDERTAKER

ADDRESS

*Joseph A. Farrell**2319 Duval*

CERTIFICATE OF DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D42232

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42232

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *317 E. Hamburg* ST. *24* WARD)2-FULL NAME *Mary A. Cline*(a) RESIDENCE. NO. *317 E. Hamburg* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND
WIFE of *James C. Cline*6 DATE OF BIRTH (month, day, and year) *May 10, 1854*

7 AGE

Years

Months

Days

IF LESS than
1 day, hrs.
or min.*60**11*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Housewife

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

John Sumwalt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md.

12 MAIDEN NAME OF MOTHER

Mary Walton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md.

14

Informant (Address)

James M. C. Cline
317 E. Hamburg St.

15

F

APR 15 1920

ROBERT A. KRAUTH
Registrar

Serial Permit 01015

20 UNDERTAKER

Ms J. E. Evans

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Balto Cent and

DATE OF BURIAL

April 1920

ADDRESS

*1428 S.*16 DATE OF DEATH (month, day, and year) *4/13/20*

17

I HEREBY CERTIFY, That I attended deceased from

4/2/20

19

to

4/13/20

19

That I last saw her alive on

4/13/20

19

and that death occurred, on the date stated above, at

1030 a

m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Endocarditis

CONTRIBUTORY (Secondary)

Interstitial nephritis(duration) *2* yrs. mos. ds.

18 Where was disease contracted If not at place of death?

I don't know

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Examination of heart

(Signed)

John Sumwalt

M. D.

(Address) *1072 West St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Balto Cent and

DATE OF BURIAL

April 1920

ADDRESS

1428 S.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42233

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42233

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *University Hospital*)

ST. *22* WARD)

REGISTERED NO. C

2-FULL NAME

Harry Womack

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *831 Leadwell st*)

St. *9th* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Oct 13, 1913
(Month) (Day) (Year)

7-AGE,

6 yrs. *5* mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

School

9-BIRTHPLACE, (State or Country),

MD

10-NAME OF FATHER,

Arthur Womack

11-BIRTHPLACE OF FATHER (State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Anna Barksdale

13-BIRTHPLACE OF MOTHER (State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

A. Womack

(Address)

831 Leadwell st

15-

FILED

APR 15 1920

ROBERT E. LAUTER

DEPT. OF HEALTH

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull caused by being struck by auto mobile truck a few hours
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Accident

(Duration) yrs. mos. ds.

(Signed) *H. K. Brown* M. D.

(Coroner.)

41-75-1920 (Address) *117 W. Saratoga St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn ct

DATE OF BURIAL,

April 15, 1920

20-INTERTAKER

H. K. Brown

ADDRESS

108 W. Monty

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42234

D42234

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 852 S Eutan ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Drummond(a) RESIDENCE. NO. 852 S Eutan ST. 3 WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds.

3

mos.

How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20 1916

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3116

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD10 NAME OF FATHER John Drummond11 BIRTHPLACE OF FATHER (city or town) (State or country) MD12 MAIDEN NAME OF MOTHER Susan Drummond13 BIRTHPLACE OF MOTHER (city or town) (State or country) VA.

14

Informant (Address) Susan Drummond
852 S Eutan

15

APR 15 1920

ROBERT E. KRAUTH
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14 19 20

17

I HEREBY CERTIFY, That I attended deceased from April 11th, 19 20, to April 14th, 19 20, that I last saw him alive on April 14th, 19 20.and that death occurred, on the date stated above, at 10:10 a m.

The CAUSE OF DEATH* was as follows:

Rochitis

CONTRIBUTORY (Secondary)

(duration) 3 yrs. 0 mos. 0 ds.(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical

(Signed)

4/14/20

19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Auburn CtApril 15 1920

20 UNDERTAKER

ADDRESS

W. L. Brown and Son 108 W. Main

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cause of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42235

CERTIFICATE OF DEATH.

D42235

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 206 PT Bechtel

ST. 3

WARD)

2-FULL NAME

Betty Petts

(Residence in Baltimore: No. 206 PT Bechtel st

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

March 1, 1920

7-AGE,

57 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (for employer)

Housewife

9-BIRTHPLACE,

(State or Country),

Va

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Robert A. Krauter

(Address)

Bank & Main

15-

APR 15 1920

ROBERT A. KRAUTER

DEPT. OF HEALTH

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 12, 1920

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

apoplexy

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. (Signed) Physician (Coroner) 4/14/20 191 (Address) 610 E. T. B. B.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

MT Zion

DATE OF BURIAL,

April 15 1920

20-UNDERTAKER

John W. Henderson

ADDRESS 1502

E. Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1042236

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Holliday

28 1042236

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Colored 11 MCA* ST. *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *1619 Druid Hill Ave* ST. *14* WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *2* yrs. *0* mos. *0* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M.* 4 COLOR OR RACE *Col.* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1885*

7 AGE Years *35* Months *—* Days *—* If LESS than 1 day, *—* hrs. *—* or *—* min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Printer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Atlanta Ga* (State or country)

10 NAME OF FATHER *George Halliday*

11 BIRTHPLACE OF FATHER (city or town) *Georgia* (State or country)

12 MAIDEN NAME OF MOTHER *Anna Lee*

13 BIRTHPLACE OF MOTHER (city or town) *Ga* (State or country)

14 Informant *M. F. J. Cooper* (Address) *1619-17 Druid Hill Ave*

15 Filed *APR 15 1920* *ROBERT F. KAUTER* Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 12 1920*

17 I HEREBY CERTIFY, That I attended deceased from *March 18, 1920*, to *April 12, 1920*, that I last saw him alive on *April 10, 1920*, and that death occurred, on the date stated above, at *8 A.M.* The CAUSE OF DEATH* was as follows:

Pneumonia
Tuberculosis
(duration) *1* yrs. *0* mos. *0* ds.

CONTRIBUTORY *Exhaustion* (Secondary) (duration) *1* yrs. *0* mos. *1* ds.

18 Where was disease contracted *?* if not at place of death?

Did an operation precede death? *No* Date of *—*

Was there an autopsy? *No*

What test confirmed diagnosis? *Physician Exam*
(Signed) *Chas P. Cantor*, M. D.

Apr 12 1920 Address *1504 McDaniel St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Atlanta Georgia* DATE OF BURIAL *Apr 15/20*

20 UNDERTAKER *W. A. Holliday* ADDRESS *1631 Broadway*
Holliday

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42237

CERTIFICATE OF DEATH.

151 D42237
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1836 Ashland ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1836 Ashland St.; yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

colored5-SINGLE, single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

April 10, 1920
(Month) (Day) (Year)

7-AGE,

yrs. mos. 2 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),Maryland

10-NAME OF FATHER,

Roosevelt Lewis11-BIRTHPLACE OF FATHER
(State or Country),Virginia

12-MAIDEN NAME OF MOTHER

Celestine Kelly13-BIRTHPLACE OF MOTHER
(State or Country),Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Celestine Kelly(Address) 1836 Ashland Ave

15-

APR 15 1920

Filed

191

ROBERT E. FRAUTER

Registrar.

Serial File # 11 018

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 12, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 10 1920, to Apr 12 1920, that I saw him alive on April 12 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)(Signed) J. E. Thomas M. D.
4-13-20 1920 (Address) 822 N. Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel

DATE OF BURIAL,

Apr 10, 1920

20-UNDERTAKER

John Holland

ADDRESS

1631 Laurel Hill Ave

important. See instructions on back of certificate.

D42238

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42238

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 N. Fulton St. ST. 15 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 1714 N. Fulton St. St. 15 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, 1857
(Month) (Day) (Year)

7-AGE, 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country) Baltimore City

10-NAME OF FATHER Anthony A. Kitter

11-BIRTHPLACE OF FATHER (State or Country) McSherrytown Pa

12-MAIDEN NAME OF MOTHER Mary Adams

13-BIRTHPLACE OF MOTHER (State or Country) Frederick Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Carroll

(Address) 1714 N. Fulton St.

15- APR 15 1920

Filed, 191. ROBERT E. KRAUTER

Serial Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH April 13, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 9 1920, to Apr 13 1920, that I saw her alive on Apr 10 1920, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Neurosyphage

(Duration) one hour yrs. mos. ds.

CONTRIBUTORY (Secondary) Atherosclerosis

(Duration) 5 yrs. mos. ds.

(Signed) E. H. Duval M. D.
Apr 13, 1920 (Address) 1817 N. Fulton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Cathedral April 16, 1920

20-UNDERTAKER ADDRESS

Martin Fahy & Sons 827 W. Pratt

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42239

CERTIFICATE OF DEATH.

D42239

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 37 S. East Ave ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Louise Brown

(a) RESIDENCE. NO.

37 S. East Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug. 9, 1869

7 AGE

Years

Months

Days

5085

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Dress maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

Charles H. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md.

12 MAIDEN NAME OF MOTHER

Minnie Overdeck

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Chas. H. Brown 37 S. East Ave

APR 15 1920

ROBERT A. BRATTON Registrar

Burial Permit Clerk

Dr. Meier

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 14 1920

17

I HEREBY CERTIFY, That I attended deceased from April 6, 1920, to April 14, 1920, that I last saw her alive on " 13, 1920, and that death occurred, on the date stated above, at 6:15 PM, m.

The CAUSE OF DEATH* was as follows:

Lobar PneumoniaCONTRIBUTORY (Secondary) Valvular Dis. Heart (duration) yrs. mos. ds. 318 Where was disease contracted if not at place of death? at homeDid an operation precede death? yes Date of Dec 1/29Was there an autopsy? noWhat test confirmed diagnosis? Physical signs(Signed) C. D. Meier, M. D., 19 (Address) 408 S. Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mount Carmel April 14 1920

20 UNDERTAKER ADDRESS

H. Sander Lou 170 Park

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42240

D42240

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 S. Milton Ave. ST.; 1 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Christian Larson(Residence in Baltimore: No. 520 S. Milton Ave. ST.; 1 WARD; 3 yrs., 3 mos., 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

Dec 28, 1920
(Month) (Day) (Year)

7-AGE,

3 yrs., 17 mos., 17 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

Balt. Md.

PARENTS.

10-NAME OF FATHER,

Christian Larson

11-BIRTHPLACE OF FATHER

(State or Country).

Balt. Md.

12-MAIDEN NAME OF MOTHER

Crystal Raither

13-BIRTHPLACE OF MOTHER

(State or Country).

Balt. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Christian Larson

(Address).

520 S. Milton Ave.

15-

Filed.

APR 15 1920

ID1.

ROBERT A. ELAISTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 14, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 2 1920, to April 14 1920, that I saw him alive on April 14 1920, and that death occurred, on the date stated above, at 8:20 a.m.

The CAUSE OF DEATH* was as follows:

Bilateral lobar pneumonia

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed)

Frank H. Langford M. D.April 14 1920 (Address) 2437 Fair St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mount Carmel

DATE OF BURIAL,

April 16 1920

20-UNDERTAKER

H. Sander Sons

ADDRESS

1710 Reed St.

CAUSE OF DEATH in plain terms, so that it may be properly examined. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42241

CERTIFICATE OF DEATH.

130 D42241

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *University Hospital* ST.; *18* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Grace Till*(a) RESIDENCE. NO. *#45 S. Poppleton* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *17* yrs. *4* mos. *6* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *f*4 COLOR OR RACE *W.*5 Single, Married, Widowed, or Divorced (write the word) *married*

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of *- Reese, Dice*6 DATE OF BIRTH (month, day, and year) *12/6/1902*

7 AGE

Years *17*Months *4*Days *6*If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Maryland*
(State or country)10 NAME OF FATHER *Wm. Gepp*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Baltimore*

14

Informant *M. Reese Dice*(Address) *115 S. Poppleton*

15

Filed *APR 15 1920*

ROBERT E. TRAUTER

Registrar

BRIAN P. HALL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/12/1920* 19

17

I HEREBY CERTIFY, That I attended deceased from

4/1, 19*20*, to *4/12*, 19*20*,that I last saw h. *h* alive on *4/12*, 19*20*.and that death occurred, on the date stated above, at *11 A* m.

The CAUSE OF DEATH* was as follows:

Septicemia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *14 mos.*(duration) yrs. mos. ds. *unknown*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*What test confirmed diagnosis? *Clinical findings*(Signed) *G. Willse* M. D.*4/12/20* (Address) *18 E Preston St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Landon Park Cem.**4/15/20*

20 UNDERTAKER

ADDRESS

John Howard & Son, 901 Hollins St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42242

CERTIFICATE OF DEATH.

79 D42242

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 Ringgold ST.; 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 303 Ringgold ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 4 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Married
5a If married, widowed, or divorced
HUSBAND of Edward Fitzgerald
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 28, 1855

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
64 4 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer9 BIRTHPLACE (city or town) Balto Md.
(State or country)

10 NAME OF FATHER Robert Hunter

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Susan Starr

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)14 Informant Mr. Ed Fitzgerald
(Address) 303 Ringgold St.

15 Robert H. Trautman

Filed

APR 15 1920

Burial

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1919, to April 13, 1920, that I last saw him alive on April 12, 1920, and that death occurred, on the date stated above, at 5 p. m.
The CAUSE OF DEATH* was as follows:Mistake Regurgitation
(duration) yrs. 4 mos. ds.CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.

4-15, 1920 Address 612 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Cathedral Cern April 16 1920

ADDRESS

John J. Corvan & Son 901 Hollins St

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42243

CERTIFICATE OF DEATH.

64 D42243

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 28 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: 54 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED, Married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Feb 6, 1866
(Month) (Day) (Year)

7-AGE,

54 yrs. 2 mos. 8 ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,
(State or Country),

Baltimore Md

PARENTS.

10-NAME OF FATHER,

Joseph Johnson

11-BIRTHPLACE OF FATHER
(State or Country),

Va

12-MAIDEN NAME OF MOTHER

Margaret Carey

13-BIRTHPLACE OF MOTHER
(State or Country),

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Franklin J. Carpenter

(Address)

3401 Morton Ave

APR 15 1920

ROBERT A. ELLAUGH

Filed..... 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 14, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

March 10th 1920, to April 14th 1920,that I saw her alive on April 13th 1920,

and that death occurred, on the date stated above, at 7:40 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

Arterio sclerosis

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

4/15, 1920 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

April 16, 1920

20-UNDERTAKER

John C. Mitchell

ADDRESS

1201 W. Hyatt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

W. May - 6th Road 57

D42244

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42244

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maud Burley(a) RESIDENCE, No. 1st street, Brooklyn. ST., WARD,

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Unknown

yrs.

mo.

How long in U. S., if of foreign birth?

yrs.

mo.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
<u>Female</u>	<u>Colored</u>	<u>Married</u>

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofEli Burley6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<u>27</u>				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Virginia10 NAME OF FATHER Andrew Jackson11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia12 MAIDEN NAME OF MOTHER Amanda Brown13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown14 Informant Hospital Records
(Address) M.T.H.15 APR 15 1920 ROBERT A. FRADETTE

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14, 1920

17

I HEREBY CERTIFY, That I attended deceased from
March 9, 1920, to April 14, 1920,that I last saw h. or alive on April 14, 1920,and that death occurred, on the date stated above, at 8.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) 18 yrs. 18 mos. ds.CONTRIBUTORY
(Secondary)(duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? No Date of Was there an autopsy? What test confirmed diagnosis? T. B. in sputum.(Signed) George R. W. Wilson, M. D.4-15-20 Address Municipal Tuberculosis Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Turner Branch

DATE OF BURIAL

April 16 1920

20 UNDERTAKER

G. A. Co., Md
John F. Denny

ADDRESS

715 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42245

CERTIFICATE OF DEATH.

105 D42245

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 437 E. Smallwood

ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Kashun E. Litchkin

(Residence in Baltimore: No. 437 E. Smallwood

St.: 20 yrs., 4 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH, *Nov. 29, 1899*
(Month) (Day) (Year)

7-AGE, *20* yrs., *4* mos., *14* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer), *At home*

9-BIRTHPLACE, (State or Country), *Dallas, Tex.*

10-NAME OF FATHER, *Adam Litchkin*

11-BIRTHPLACE OF FATHER, (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER, *Christina Stas*

13-BIRTHPLACE OF MOTHER, (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Fredrick M. Litchkin*

(Address), *437 E. Smallwood St.*

15-ROBERT F. TRAUTER

Filed *APR 15 1920* Social. P. M. L. Olap

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 12, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 4, 1920*, to *April 12, 1920*, that I saw her alive on *April 12, 1920*, and that death occurred, on the date stated above, at *12-38* m. The CAUSE OF DEATH* was as follows:

Acute Enteric Poliphia

CONTRIBUTORY... *Exhaustion* 7 ds.
(Secondary)

(Signed) *[Signature]* M. D.
4/12/20, 1920 (Address) *1735 17th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Trinity Cemetery *Apr. 15, 1920*

UNDERTAKER

ADDRESS

George E. Schwartz *Bro 211 Park Ave*

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42246

CERTIFICATE OF DEATH

D42246

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Cooks Lane* ST. *28* WARD)

2-FULL NAME *Elizabeth Dorothy Cook*

(Residence in Baltimore: No. *Cooks Lane* St. *58* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married* (Write the word)

6-DATE OF BIRTH *Feb 12, 1839* (Month) (Day) (Year)

7-AGE *81* yrs. *2* mos. *7* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer) *At Home* 037

9-BIRTHPLACE (State or country) *Ellicott City, Md.*

10-NAME OF FATHER *John Frederick Pfeffer*

11-BIRTHPLACE OF FATHER (State or country) *Germany*

12-MAIDEN NAME OF MOTHER *Katharine Justina Ruff*

13-BIRTHPLACE OF MOTHER (State or country) *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *John Cook*

(Address) *Cooks Lane*

15-APR 15 1920 ROBERT H. KAUFMAN

Filed

Barial Fairs REGISTRATION

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *April 14, 1920* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept*, 1919, to *April 14*, 1920, that I saw her alive on *April 13*, 1920, and that death occurred, on the date stated above, at *4 a.* m. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Contributory *Arterio Sclerosis* (Duration) *1* yrs. *8* mos. ds.

(Signed) *Marshall B. West* M. D. *April 14, 1920* (Address) *Catonsville*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *New Cathedral Cem.* DATE OF BURIAL *Apr. 17, 1920*

20-UNDERTAKER *Joseph B. Cook* ADDRESS *1013 N. Baltimore St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42247

D42247

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 N. Curley ST.;

WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Daniel Flessner

(Residence in Baltimore: No. 724 N. Curley

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

M

4-COLOR OR RACE,

W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH,

August 25, 1920
(Month) (Day) (Year)

7-AGE,

yrs. 7 mos. 19 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

Stephen Flessner

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Julia Schaeffer

13-BIRTHPLACE OF MOTHER
(State or Country),

Pittsburg

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Stephen Flessner

(Address).....

724 N. Curley

15-

APR 15 1920

ROBERT B. KRAUTER

Filed

Burial Permit Registered

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 13, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from March 15, 1920, to April 13, 1920, that I saw him alive on April 13, 1920, and that death occurred, on the date stated above, at 60 m. The CAUSE OF DEATH* was as follows:

Sympho Sarcoma

CONTRIBUTORY
(Secondary)

(Duration) yrs. 1 mos. 4 ds.

Cardiac Exhaustion

(Duration) yrs. 2 mos. 2 ds.

(Signed) William J. H. H. M. D.

April 14, 1920 (Address) 201 N. Ketchum

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

April 15, 1920

20-UNDERTAKER

Mendell Appel 378 N.

ADDRESS

D42248

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 D42248

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sp. Josephs Hospital ST.: 3 WARD)2-FULL NAME Salvatore Papio(a) RESIDENCE. No. 217 President ST.: _____ WARD. _____

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. _____ mos. _____ ds.How long in U. S., if of foreign birth? 43 yrs. _____ mos. _____ ds.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francesca Papio6 DATE OF BIRTH (month, day, and year) April 5 1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

72

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Hotel-keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy10 NAME OF FATHER Antonio Papio11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy12 MAIDEN NAME OF MOTHER Don't know13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14

Informant (Address) Elizabeth Riosore
217 President

15

Filed

APR 15 1920

ROBERT E. LAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1920

17

I HEREBY CERTIFY, That I attended deceased from April 12 1920, to April 13 1920 that I last saw him alive on April 13 1920 and that death occurred, on the date stated above, at 10:10 P. m. The CAUSE OF DEATH* was as follows:Pulmonary edema
14 hrsCONTRIBUTORY (Secondary) Lobar Pneumonia (duration) _____ yrs. _____ mos. _____ ds.18 Where was disease contracted if not at place of death? unknownDid an operation precede death? no Date of _____Was there an autopsy? noWhat test confirmed diagnosis? signs & symptoms(Signed) Daniel M. Reed, M. D., 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Vincent
20 UNDERTAKER Wendell D. JohnsonApril 7 1920
ADDRESS 318 mm

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42249

CERTIFICATE OF DEATH.

128 D42249

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Josephs Hospital* ST.: *26* WARD)2-FULL NAME *Margaret Zeiler*(a) RESIDENCE, NO. *Foster Ave 2 3rd* ST. *26* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *28* yrs. *2* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Charles H. Zeiler*6 DATE OF BIRTH (month, day, and year) *Jan 2nd 1892*7 AGE Years *28* Months *2* Days *15* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *at Home*

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Md.* (State or country)10 NAME OF FATHER *John Zeiler*11 BIRTHPLACE OF FATHER (city or town) *Balto. Md.* (State or country)12 MAIDEN NAME OF MOTHER *Margt. Champness*13 BIRTHPLACE OF MOTHER (city or town) *Balto. Md.* (State or country)

14

Informant *Charles H. Zeiler* (Address) *403 E. 3rd*

15

APR 15 1920

ROBERT A. TRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 14th 1920*17 I HEREBY CERTIFY, That I attended deceased from *April 12*, 19*20*, to *April 14*, 19*20*, that I last saw her alive on *April 14*, 19*20*, and that death occurred, on the date stated above, at *10 A.* m.

The CAUSE OF DEATH* was as follows:

*Pulmonary edema*CONTRIBUTORY *Eclampsia* (Secondary) (duration) yrs. mos. *1* ds.18 Where was disease contracted *Indefinitely* If not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *supra symptoms* (Signed) *David Miller*, M. D.19 (Address) *St Josephs Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Sacred Heart Cemetery April 17 1920

20 UNDERTAKER

Lilly & Zeiler

ADDRESS

403 E. 3rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D42250

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42250

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1407 N Montford ave ST.; 8

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Florence Caroline Mayer

(a) RESIDENCE. No.

1407 N. Montford ave ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 2 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

February 9th 1896

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

24

2

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at School

(b) General nature of industry, business, or establishment in which employed (or employer)

Boucher College

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Michael Mayer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt Md

12 MAIDEN NAME OF MOTHER

Emma Deller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt Md

14

Informant (Address)

Emma Mayer 1407 N. Montford ave

15

File

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 13th 1920

17

I HEREBY CERTIFY, That I attended deceased from

apl 6 1920 to apl 13 1920

that I last saw her alive on 10 1920

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 3 yrs (from Tuberc.) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

" "

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

April 15th 1920

20 UNDERTAKER

ADDRESS

George Schilling & Sons

1126 Monument

APR 15 1920

D42251

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42251

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

APR 15 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 11 1920, to April 13 1920,

that I last saw her alive on April 13 1920,

and that death occurred, on the date stated above, at 12⁵⁰ p. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) R. B. Bloomfield, M. D.

19 (Address) 1115 Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

April 16 1920

20 UNDERTAKER

Mrs. C. Butler

ADDRESS

2334 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D42252

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42252

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

936 Harford Ave. 10

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Louisa Yahunka

(Residence in Baltimore: No.

936 Harford Ave.

St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Widowed

6-DATE OF BIRTH,

Sept. 5, 1841
(Month) (Day) (Year)

7-AGE,

78 yrs. 7 mos. 9 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

At home

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER (State or Country),

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or Country),

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Mr. Charles Yahunka

(Address).....

936 Harford Ave.

15-

APR 15 1920

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 1916, to April 14 1920,
that I saw h. alive on April 14 1920,

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Eugene Miller M. D.

4/14, 1920. (Address) 1818 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Trinity Cemetery

April 14 1920

20-UNDERTAKER

ADDRESS

Mrs. E. Miller

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42253

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42253

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *1417 Eastern Ave* St.: *2* WARD)2-FULL NAME *Baustance Di Tropane*(Residence in Baltimore: No. *1417 Eastern Ave* St.: yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE, *White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH, *April 15, 1920*
(Month) (Day) (Year)7-AGE, *2*
yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Simon Di Tropane*11-BIRTHPLACE OF FATHER (State or Country), *Italy*12-MAIDEN NAME OF MOTHER, *Antonette Barla*13-BIRTHPLACE OF MOTHER (State or Country), *Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Simon Di Tropane*(Address) *1417 Eastern Ave*

15-

Robert P. Harrison,

APR 15 1920

101

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 15, 1920*
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debitity

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Henry Shaw Prisker* M. D.
(Coroner.)4/15/20 (Address) *1610 6th St. Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St Vincent Cemetery*DATE OF BURIAL, *April 16 1920*

20-UNDERTAKER

ADDRESS

George J. Rusk 1735 Haddon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42254

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42254

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 440 E. 20th ST.; 17th WARD)

2-FULL NAME

(a) RESIDENCE. NO. 440 E. 20th

(Usual place of abode)

Length of residence in city or town where death occurred

Lifes yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Alice A. Sinclair

6 DATE OF BIRTH (month, day, and year)

Jan 17, 1861

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

59

2

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Retired

Cigar Mfg.

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Henry Sinclair

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Bernice Schwab

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant

(Address)

Alice A. Sinclair

440 E. 20th St.

Robert P. Harrison, Registrar

15

APR 15 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 15, 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 14, 1920, to April 15, 1920

that last saw him alive on April 14, 1920

and that death occurred, on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 12 mos.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald J. Tonny, M. D.

, 19 (Address) 444 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Landon Park

20 UNDERTAKER

Howe

DATE OF BURIAL

4/17 1920

ADDRESS

H. E. Mc

D42255

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42255

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; (yrs. 20) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day (stated above).

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY

(Second)

(Signed) M. D.

(Address) (City & State)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

APR 15 1920

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42256

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42256

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2308 Eutaw Place WARD 13)

2-FULL NAME

Frances Edwin Jewell

(a) RESIDENCE. No.

2308 Eutaw Place

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs.

mos.

ds. How long in U. S., if of foreign birth? Life yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofFlorence E. Jewell

6 DATE OF BIRTH (month, day, and year)

Nov 27 - 1856

7 AGE

Years

Months

Days

If LESS than

63418I day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workBuilder(b) General nature of industry,
business, or establishment in
which employed (or employer)Real Estate

(c) Name of employer

Self

9 BIRTHPLACE (city or town)

(State or country)

a. a. co

10 NAME OF FATHER

James T. Jewell

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

md

12 MAIDEN NAME OF MOTHER

Henrietta Weedon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

md

14

Informant
(Address)Florence E. Jewell
2308 Eutaw Place

APR 15 1920

APR 15 1920

Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 14 - 1920

17

I HEREBY CERTIFY, That I attended deceased from

3 - 10 - 1920, to 4 - 14 - 1920,that I last saw him alive on 4 - 13 - 1920,and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis,Cerebral Hemorrhage(duration) 1 yrs. 2 mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. A. Duval M. D.19 (Address) 3523 Liberty Hgts an*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park CemApr 16 1920

20 UNDERTAKER

ADDRESS

Wm. J. KuehnNorth St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D42257

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D42257

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes' Hospital* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs. E. Elvira Long

(a) RESIDENCE. No.

1020 Linden Ave.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

69 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Edwin Long*

6 DATE OF BIRTH (month, day, and year)

Sept 12-1850

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*69 yrs**7**2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

"

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*"**"**"*

14

Informant
(Address)*Mr. Chas. Gordon
1020 Linden Ave.*

15

Filed

19

Robert F. Harrison,

Registrar

APR 15 1920

APR 15 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 14 1920

17

I HEREBY CERTIFY, That I attended deceased from

*4-11-1920, to 4-14-1920,*that I last saw him alive on *4-14-1920*and that death occurred, on the date stated above, at *3:45 p.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast(duration) yrs. *6 mos.* ds.

CONTRIBUTORY (Secondary)

Acute dilatation of heart.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *yes* Date of *4-12-20*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *E. H. Adams*, M. D., 19 (Address) *St. Agnes' Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery Apr 16 1920

20 UNDERTAKER

ADDRESS

Wm. J. McKenney N. & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42258

D42258

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4316 Belview Ave. 28 WARD)

2-FULL NAME

Helen Louise Green

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE, No. 4316 Belview Ave. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 7 1905

7 AGE Years 15 Months 1 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Brooklyn N.Y. (State or country)

10 NAME OF FATHER Fredk. W. Green

11 BIRTHPLACE OF FATHER (city or town) Mass. (State or country)

12 MAIDEN NAME OF MOTHER Mrs. Ann Green

13 BIRTHPLACE OF MOTHER (city or town) Brooklyn N.Y. (State or country)

14

Informant (Address) 720 Green 4316 Belview

ROBERT F. HARRISON

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Mar 11, 1920, to April 13, 1920, that I last saw h^e alive on April 13, 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

CONTRIBUTORY (Secondary) Rheumatism (duration) 1 yrs. mos. ds.

18 Where was disease contracted If not at place of death? Bath

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. C. Dean M. D.

Address 2600 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cem. April 16 1920

20 UNDERTAKER

ADDRESS

Wm. J. Teckmeyer N.Y.P.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 15 1920

APR 15 1920

D42259

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D42259

CERTIFICATE OF DEATH.

1-PLACE OF DEATH.

CITY OF BALTIMORE: (No. *1910 Patterson Pk. Ave.* ST.; *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John Robert Griffin*(Residence in Baltimore: No. *1910 Patterson Park Ave.* St.; *2* yrs., *4* mos., *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Feb. *10*, 19*20*
(Month) (Day) (Year)

7-AGE,

2 yrs., *4* mos., *4* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), *Baltimore, Md.*10-NAME OF FATHER, *Thos. M. Griffin*11-BIRTHPLACE OF FATHER (State or Country), *Penna.*12-MAIDEN NAME OF MOTHER *Anna S. Malley*13-BIRTHPLACE OF MOTHER (State or Country), *Penna.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Anna S. Griffin*(Address) *1910 Patterson Pk. Ave.*

15-

APR 15 1920 Robert P. Harrison,
191....., 191.....

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April *15*, 19*20*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *April 12*, 19*20*, to *April 14*, 19*20*, that I saw him alive on *April 14*, 19*20*, and that death occurred, on the date stated above, at *8 A.* m.

The CAUSE OF DEATH* was as follows:

Enteritis(Duration).....yrs.....mos. *2* ds.CONTRIBUTORY (Secondary) *Convulsions*(Duration).....yrs.....mos. *1* ds.(Signed) *John D. Quinn* M. D.*April 15*, 19*20* (Address) *1507 4th Fulton Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL *April 15**Holy Cross Parsonage Rd., 1920*

20-UNDERTAKER

ADDRESS

Wm Cook 502 C. York Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1090 Bks.

D42260

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42260

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *15* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs Mary Steele*

(a) RESIDENCE. No. *1807 Baker* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Wm. Steele*

6 DATE OF BIRTH (month, day, and year) *1875*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *45*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None* (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) *Balto* (State or country) *Ms*

10 NAME OF FATHER *James Garry*

11 BIRTHPLACE OF FATHER (city or town) *Ireland* (State or country)

12 MAIDEN NAME OF MOTHER *Rose Frey*

13 BIRTHPLACE OF MOTHER (city or town) *Balto* (State or country) *Ms*

14 Informant *W. Steele* (Address) *1807 Baker St.*

15 File *APR 16 1920* *ROBERT H. KAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 15 1920*

17 I HEREBY CERTIFY, That I attended deceased from *Mar 22*, 19 *20*, to *Apr 15*, 19 *20*, that I last saw her alive on *Apr 15*, 19 *20*, and that death occurred, on the date stated above, at *8:25 P.* m.

The CAUSE OF DEATH* was as follows: *Carcinoma of breast*

CONTRIBUTORY (Secondary) *Spinal metastases* (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. O. Ridgely* M. D. (Address) *Mercy Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Calhoun *Apr 19 1920* *J. McCully* *128 E. 6th Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42261

CERTIFICATE OF DEATH.

104

D42261

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 S Caroline ST.; 3 WARD)

2-FULL NAME

Clarence Britt Jr

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 107 S Caroline St.; 0 yrs., 0 mos., 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Black5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word)Single

6-DATE OF BIRTH,

March 30, 1920
(Month) (Day) (Year)

7-AGE,

15 ds.
yrs. mos. ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, business,
or establishment in which
employed (or employer).....9-BIRTHPLACE,
(State or Country),md

PARENTS.

10-NAME OF
FATHER,Clarence Britt11-BIRTHPLACE
OF FATHER
(State or Country),N. C.12-MAIDEN NAME
OF MOTHERCatharine Ferebe13-BIRTHPLACE
OF MOTHER
(State or Country),md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. E. Duncan(Address) Johns Hopkins Hospital.15-
APR 16 1920

Filed....., 191.....

ROBERT S. KRAUTER

Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 14, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
March 30, 1920, to April 14, 1920,
that I saw him alive on April 14, 1920,
and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Gastro-Intestinal
Indigestion.
(Duration) 0 yrs. 0 mos. 3 ds.CONTRIBUTORY
(Secondary)(Signed) John W. Harrison M. D.
4/15/20, (Address) Johns Hopkins Hospital*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

Laurel

DATE OF BURIAL,

4/16/20; 191...

20-UNDERTAKER

John W. Henderson

ADDRESS

1102

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42262

CERTIFICATE OF DEATH.

D42262

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (NO.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Harris Belman.

(Residence in Baltimore: No.

248 S. Caroline

St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH

Unknown

1874

(Month)

(Day)

(Year)

7-AGE

46

yrs. — mos. — ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Tailor

9-BIRTHPLACE,

(State or Country),

Russia

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jack Lewis

(Address)

1411 E. Pratt St.

15-

Filed APR 16 1920

DOCKET 1 MASTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April

15

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

4-13-1920, to 4-15-1920,

that I saw him alive on 4-15-1920,

and that death occurred, on the date stated above, at 12 AM.

The CAUSE OF DEATH* was as follows:

Emphysema
Chronic Bronchitis
Cardiac hypertrophy + dilatation

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....Dilated rt. heart
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....Benj. Sachs.....M. D.

Apr. 15, 1920. (Address).....Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....2 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....248 S. Caroline St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew Hespung Cem

Apr. 16, 1920

20-UNDERTAKER

ADDRESS

Jack Lewis

1411 E. Pratt St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42263

CERTIFICATE OF DEATH.

D42263

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *1800 Harlem Ave* ST.; *16* WARD)

2-FULL NAME

Mathilda May

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1400 Harlem Ave* St.; *69* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *F* 4-COLOR OR RACE, *W.* 5-SINGLE, *Widow*, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, *July* *24*, *1850*
(Month) (Day) (Year)7-AGE, *69* yrs., *8* mos., *21* ds. If LESS than 1 day,hrs. ormin.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Iron*
(b) General nature of industry, business, or establishment in which employed (or employer), *Iron*9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *John S. Herkelman*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER, *Catherine Barbach*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Fredrick B. Maag*(Address) *1400 Harlem Ave*

15-APR 16 1920 ROBERT F. KRAUTER

Filed *1920* Social Path (R-101)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April* *14*, *1920*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Feb 1* 1920, to *April 14* 1920, that I saw her alive on *April 14* 1920, and that death occurred, on the date stated above, at *110* m. The CAUSE OF DEATH* was as follows:*Carcinoma of Throat*

(Duration)yrs.mos.ds.

CONTRIBUTORY (Secondary) *Alcoholism*

(Duration)yrs.mos.ds.

(Signed) *J. J. Jones* M. D.*4/15*, 1920. (Address) *509 Cathedral St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Most Holy Redeemer *Apr. 17, 1920*

20-UNDERTAKER ADDRESS

Henry & Branning Son *Schraeder*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42264

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1113 N. Vincent*

ST. *16* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Archie Fletcher

(Residence in Baltimore: No. *1113 N. Vincent*

St.; yrs. *30* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

1871
(Month) (Day) (Year)

7-AGE,

49 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Domestic

9-BIRTHPLACE, (State or Country),

va

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William Thomas*

(Address) *1013 N. Lexington St.*

15-

APR 16 1920 ROBERT B. FAUTER

Filed

191

BALTIMORE, MARYLAND

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr. 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. E. Smith* M. D.
(Coroner)

1920 (Address) *910 Lexington St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Andrew

April 16, 1920

20-UNDERTAKER

ADDRESS *114 N*

Brown and Ireland School St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42265

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 214 Rock Court

ST.: 18

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 214 Rock Court

St. 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Don't know, 1865

7-AGE,

an old about 55

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Laborn / O.D.

9-BIRTHPLACE, (State or Country),

va

10-NAME OF FATHER,

Don't know

11-BIRTHPLACE OF FATHER (State or Country),

Don't know

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER (State or Country),

Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jerry Turner

(Address)

214 Rock Court

15-

File

APR 16 1920

ROBERT E. KRAUTH

RECEIVED

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 13, 1920

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)

and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nerve Poisoning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Asphyxiation

(Duration) yrs. mos. ds.

(Signed)

W. K. Garrison M. D.

(Coroner.)

4-14-1920 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

At Auburn

DATE OF BURIAL,

April 16 1920

20-UNDERTAKER

Brown & Piesand

ADDRESS 114 N.

Schroeder St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42266

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42266

PLACE OF DEATH

CITY OF BALTIMORE (No. *6th & Melkins Ave* ST. *20* WARD)

2-FULL NAME *Thomas B Vinyard*

(Residence in Baltimore: No. *2010 Ramsey St.*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *Life* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male*

4-COLOR OR RACE, *white*

5-SINGLE *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH, *week 4, 1857*

(Month)

(Day)

(Year)

7-AGE, *63*

yrs.

1 mos.

10 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Labors*

(b) General nature of industry, business, or establishment in which employed (or employer). *Stock yard*

9-BIRTHPLACE, *Balto md.*

PARENTS.

10-NAME OF FATHER, *Jas. Vinyard*

11-BIRTHPLACE OF FATHER, *md.*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER, *md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Anna Vinyard*

(Address) *2010 Ramsey St.*

15-

APR 16 1920

ROBERT F. KAUTER

Serial Form 100-1000

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Apr. 14, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest find that said deceased came to death top or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Pyemic Heart disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. Ed. Smith* M. D.

Apr 14 1920 (Address) *910 Light St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *St Pauls Violetville*

DATE OF BURIAL, *Apr 16, 1920*

20-UNDERTAKER

ADDRESS

Geo. Heber & Son 2503 Edmondson Ave

D42267

D42267

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 01551 Friendstury St.; 42 yrs., 5 mos., 8 ds.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 15, 1920
(Month) (Day) (Year)

No. 1 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1919, to April 14, 19120, that I saw him alive on April 14, 19120, and that death occurred, on the date stated above, at 1:45 a.m.

The CAUSE OF DEATH* was as follows:
 Chronic Mitral Stenosis
 Disease
 (Duration) yrs. 5 mos. 10

CONTRIBUTORY.....
(Secondary).....
..... (Duration)..... yrs..... mos..... ds.

(Signed) John R. Linn M. D.
 Date, May 15, 1913 (Address) 1507 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or
Usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.

20-UNDERTAKER	ADDRESS
---------------	---------

Los Angeles Superior North
ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42268

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 Bradford St. ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1515 Orleans St. St.; life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Colored5-SINGLE,
MARRIED, Married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH:

September 13, 1897
(Month) (Day) (Year)

7-AGE,

22 yrs. 7 mos. ds.If LESS than 1 day,
....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....House mother(b) General nature of industry, business, or establishment in which employed (or employer).....039-BIRTHPLACE,
(State or Country),Baltimore, Md.

PARENTS.

10-NAME OF FATHER,

William Bosley11-BIRTHPLACE OF FATHER
(State or Country),North Carolina

12-MAIDEN NAME OF MOTHER

Eddie Thomas13-BIRTHPLACE OF MOTHER
(State or Country),Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Mary Holt(Address).....1724 McCallister

15-APR 16 1920

ROBERT I. KAUFMAN

Filed....., 191....April 16 Permit.....042268
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 13, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 10, 1920, to April 13, 1920,that I saw her alive on April 13, 1920,and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Peritonitis 2 days duration, due to enteric fever and ovarian inflammation following accidental abortion.
(Duration).....2 days

CONTRIBUTORY (Secondary)

one month prior to death.
(Duration).....1 mos. ds.(Signed).....Richard B. Galt M. D.April 13, 1920 (Address).....1514 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....1 yrs. 7 mos. ds. In the State.....1 yrs. 7 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Bolton Cemetery April 16, 1920

20-UNDERTAKER

ADDRESS

Milton Davis 413 N. Eden St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19-H. P. Co.-1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE
D42269 120 D42269

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* ST. *3* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Harro London*

(a) RESIDENCE. No. *129 S. Caroline* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *12* yrs. mos. ds.

How long in U. S., if of foreign birth? *12* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

wife

6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Porto Mary 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Fifish London

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Mytham London 129 S. Caroline St

15

Filed

APR 16 1920

ROBERT E. KAUFMAN

Dr. J. P. Smith

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/16* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

April 14 19 *20*, to *April 16* 19 *20*,

that I last saw him alive on *April 16* 19 *20*

and that death occurred, on the date stated above, at *8 4* m.

The CAUSE OF DEATH* was as follows:

Chronic Tubercular Nephritis

CONTRIBUTORY (Secondary)

(duration) *3* yrs. mos. ds.

(duration) yrs. mos. *9* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Joseph Sudler* M. D.

4/16 1920 (Address) *Mary Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Highwood Road

April 16 1920

20 UNDERTAKER

ADDRESS *1127*

Max Linsan

E. Baltz

D42270

HEALTH DEPARTMENT—CITY OF BALTIMORE

42270

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE:

ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Minnie C. Kelly.

(a) RESIDENCE. NO.

1514 John St.

ST. WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred

5 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

yes. married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Frank Welch

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

LI

14

Informant (Address)

University Hospital Records

15

Filed

APR 16 1920

ROBERT E. LEATHER

Burial Permit Closed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-14-1920

17 I HEREBY CERTIFY, That I attended deceased from

4-14-1920, to 4-15-1920,

that I last saw him alive on 4-14-1920,

and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

General peritonitis
(following perforated stomach)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocardial insuff.

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

unknown

Did an operation precede death? yes Date of 4-14-20

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) H. M. Stein, M. D.

19 (Address) Mr. W. P. Whittier

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

April 17 1920

20 UNDERTAKER

Chas. E. French 807 Madison

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42271

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42271

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3541 Liberty Heights Ave. 15 ST. WARD)

2-FULL NAME

(Residence in Baltimore: No. 3541 Liberty Heights Ave. St. 15 yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH,

Oct 26, 1843 (Month) (Day) (Year)

7-AGE,

76 yrs. 2 mos. 17 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

Court Employee

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

PARENTS.

10-NAME OF FATHER,

Joseph W. Eggleston

11-BIRTHPLACE OF FATHER,

(State or Country),

Balto. Md.

12-MAIDEN NAME OF MOTHER,

Anna Dittmar

13-BIRTHPLACE OF MOTHER,

(State or Country),

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

APR 16 1920

Filed

191

ROBERT F. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr. 13, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, And that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

(Coroner)

4/13, 1920

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Loudon Park Cemetery

DATE OF BURIAL,

4/16....., 1920

20-UNDERTAKER

Henry W. Hears & Son

ADDRESS

805 W. Calvert St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19-H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42272

CERTIFICATE OF DEATH.

28 D42272

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 453 Orchard ST. 11 WARD)

2-FULL NAME Randolf Mc Daniel

(a) RESIDENCE. No. 453 Orchard ST. 11 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? Life mos. 1 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE coloured 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Lottie McDaniel

6 DATE OF BIRTH (month, day, and year) Nov. 17, 1875

7 AGE Years 45 Months 1 Days 14 If LESS than 1 day, 1 hrs. 14 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer) Powerhouse

(c) Name of employer United Ry. & E. Co.

9 BIRTHPLACE (city or town) W. Va. (State or country)

10 NAME OF FATHER John McDaniel

11 BIRTHPLACE OF FATHER (city or town) W. Va. (State or country)

12 MAIDEN NAME OF MOTHER Alice McDaniel

13 BIRTHPLACE OF MOTHER (city or town) W. Va. (State or country)

14 Informant Mrs. Lottie McDaniel (Wife) (Address) 453 Orchard Street

15 APR 6 1920 ROBERT B. TRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 15, 1920

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1920, to April 15, 1920, that I last saw him alive on April 15, 1920, and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) 10 yrs. 10 mos. 1 ds.

CONTRIBUTORY Occupation + exposure (Secondary) (duration) 10 yrs. 10 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician's report (Signed) Edward J. Wheeler M. D. (Address) 1234 David St. W. Va.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL April 18, 1920

20 UNDERTAKER Mrs. McJohnson ADDRESS 1234 Etting St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42273 HEALTH DEPARTMENT—CITY OF BALTIMORE D42273

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 771 P Smwood Ave ST.: 1 WARD)
2-FULL NAME Francis X. Sparney
(Residence in Baltimore: No. 771 P Smwood Ave St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male	4-COLOR OR RACE, White	5-SINGLE MARRIED WIDOWED OR DIVORCED. (Write the word.) Single
6-DATE OF BIRTH, Jan 16, 1920 (Month) (Day) (Year)		
7-AGE, 3 yrs., 6 mos., ds. If LESS than 1 day,hrs. or....min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). None		
9-BIRTHPLACE, (State or Country), Baltimore, Md.		
PARENTS.	10-NAME OF FATHER, Francis A. Sparney	
	11-BIRTHPLACE OF FATHER (State or Country), Baltimore	
	12-MAIDEN NAME OF MOTHER, Julia Stomolawsky	
	13-BIRTHPLACE OF MOTHER (State or Country), Baltimore	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Francis A. Sparney
(Address) 771 P Smwood Ave

15-APR 16 1920
Filed..... 101. ROBERT E. KRAUTER
Special Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute gastro-enteritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)
(Duration).....yrs.....mos.....ds.

(Signed) Henry Small, D. M. D.
(Coroner)
4/15/20 (Address) 1610 E. 34th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, DATE OF BURIAL,

Holy Rosary April 16 1920

20-UNDERTAKER ADDRESS


Wendell Dwyer 37 S. Ann St.

I do hereby make oath to the following changes on
Baltimore City Health Department Certificate of Death, No. D-42273,
as follows:-

Date of birth should be February 13, 1920, instead of
January 16, 1920.

Name of Person - Frank A. Sporny instead of
Francis H. Sporney.

Name of Father - Frank Sporny, instead of
Frances A. Sporney.


Channing Lloyd Perkins
Physician.

Subscribed and sworn to before me this 28th day of April, 1920.

Reed Gaither
Notary Public.

D42274

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42274

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 N. Chapel

ST.: 7

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 917 N. Chapel

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Joseph Setelak

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Berrenq Bohemia (State or country)

10 NAME OF FATHER Frank Petlak

11 BIRTHPLACE OF FATHER (city or town) Berrenq Bohemia (State or country)

12 MAIDEN NAME OF MOTHER Marie Meyerova

13 BIRTHPLACE OF MOTHER (city or town) Berrenq Bohemia (State or country)

14

Informant (Address) Joseph Setelak 917 N. Chapel St.

15

Filed

APR 16 1920

ROBERT E. KAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jul 16 1920

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1920, to April 16, 1920, that I last saw her alive on April 16, 1920, and that death occurred, on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Gallstones Inflammation of Gall bladder, Hypertension, Nephritis, Myocarditis, Endocarditis

CONTRIBUTORY (Secondary)

Acute Cardiac Dilatation (duration) yrs. 3 mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J. M. Meyer

M. D.

4-17-19 (Address) 800 N. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

Jul 19 1920

20 UNDERTAKER

Frank Crockett

ADDRESS

1806 Ashland St.

D42275

HEALTH DEPARTMENT—CITY OF BALTIMORE D42275

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *22 S Bettel* ST.: *3* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Maggie Williams*(Residence in Baltimore: No. *22 S. Bettel St.* St.: *25* yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *Colored*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *Unknown*, 1872

(Month) (Day) (Year)

7-AGE, *48* yrs. — mos. — ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Cook*(b) General nature of industry, business, or establishment in which employed (or employer), *02*9-BIRTHPLACE, (State or Country), *York Pa*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Unknown*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *John Williams*(Address), *22 S. Bettel St.*

15-

Filed *APR 16 1920*

191

ROBERT F. KRAUTER

Serial Permit *CLARK*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Apr 14*, 1920

(Month) (Day) (Year)

17- I HEREBY CERTIFY. That I attended deceased from *Apr 13 1920* to *Apr 13 1920*,that I saw her alive on *Apr 13 1920*, and that death occurred, on the date stated above, at *3 P.* m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Mitral & Aortic Insufficiency*

(Duration) yrs. mos. ds.

(Signed) *Nathan Helfert* M. D.*Apr 15 1920* (Address) *117 S. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Laurel cemetery*DATE OF BURIAL, *Apr 16 1920*20-UNDERTAKER, *Moore & Elliott*ADDRESS *1725*

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42276

CERTIFICATE OF DEATH.

120 2276

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2122 Swinton ST.; 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 2122 Swinton ST., 14 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Caucasian 5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow6 DATE OF BIRTH (month, day, and year) February7 AGE Years 40 Months - Days - If LESS than 1 day, hrs. - or min. -

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)10 NAME OF FATHER Wilson Sinker11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)12 MAIDEN NAME OF MOTHER Ann Kuhn13 BIRTHPLACE OF MOTHER (city or town) Ann Kuhn (State or country)14 Informant Charles Sinker (Address) 2122 Swinton St.15 Filed APR 16 1920 DOCKET & REAVERSBurial Permit 01851

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 14 192017 I HEREBY CERTIFY, That I attended deceased from April 13, 1920, to April 14, 1920, that I last saw him alive on April 13, 1920, and that death occurred, on the date stated above, at 6.00 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Coronary Disease(duration) yrs. mos. ds. 3

CONTRIBUTORY (Secondary)

Intestinal Infection(duration) yrs. mos. ds. 1

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Hester M. D., 19 (Address) 2008 Eastern Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Auburn April 18 1920

20 UNDERTAKER

James H. Dennis 1309 Presbiterian

Information should be given in plain terms, so that it may be properly understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

D42277

HEALTH DEPARTMENT—CITY OF BALTIMORE

12277

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3816 Foster Ave ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE

No.

3816 Foster Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

2 yrs.8 mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

8/6/17

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.28

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Balto

10 NAME OF FATHER

Charles Selig11 BIRTHPLACE OF FATHER (city or town)
(State or country)Balto

12 MAIDEN NAME OF MOTHER

Mary Malet13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Balto

14

Informant
(Address)Frank Malet
721 S. Montford Ave

15

Filed

APR 16 1920ROBERT E. KAUFMAN
Registrar
Serial Permit 6102

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 16 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 4, 1920, to April 15, 1920,that I last saw him alive on April 15, 1920,and that death occurred, on the date stated above, at 1 PM m.

The CAUSE OF DEATH* was as follows:

measles(duration) yrs. mos. 12 ds.CONTRIBUTORY
(Secondary)Brown Pneumonia(duration) yrs. mos. 1 ds.18 Where was disease contracted
if not at place of death?HomeDid an operation precede death? yes Date of March 16 20Was there an autopsy? noWhat test confirmed diagnosis? Eruptive fever(Signed) W. R. Burke M. D., 19 (Address) 3042 Hudson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Church April 17 1920

20 UNDERTAKER

ADDRESS

Joe J. Dyer 156 N. Lexington

Information should be given in plain terms, so that it may be properly understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42278

CERTIFICATE OF DEATH.

D42278

PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.:

WARD)

REGISTERED No. C

2-FULL NAME

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILED

APR 16 1920

ROBERT E. KRAUTER

Bureau of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said

and that said deceased came to

on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park

April 16, 1920

20-UNDERTAKER

ADDRESS

W. W. Shuie

108 Edmondson Ave

N. B.—Every item of information should be carefully checked, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42279

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

29 yrs.

mos.

ds. How long in U. S., if of foreign birth?

29 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Married

6a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Ferdinand Kahl

6 DATE OF BIRTH (month, day, and year)

June 9, 1862

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

57

9

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 637

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

George A. Garbrig

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Don't know

14

Informant (Address)

Ferdinand Kahl 5th St. Fairfield

APR 16 1920

ROBERT R. LEAUTE

Registrar

Serial Permit Closed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 14 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 20, 1919, to April 14, 1920.

that I last saw her alive on April 13, 1920.

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Saint Ann's

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

19 (Address) 1340 S. Chene

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lorraine Cemetery

April 24, 1920

20 UNDERTAKER

ADDRESS

M. L. Flynn

1422 Light

Brooklyn, Maryland,

August 6th, 1920.

Personally appeared before me this 6th day of August 1920
Ferdinand Kahl, and made oath that the place of birth of the mother
of Hattie Kahl, who died on April 14th, 1920, should have been given
as Germany in the death certificate of said deceased.

W. C. Bourke Jr
Notary Public.

Ferdinand Kahl

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HEALTH DEPARTMENT—CITY OF BALTIMORE

D42280

CERTIFICATE OF DEATH.

180

D42280

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes Hospital* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mr. Michael Hogan

(a) RESIDENCE. NO.

1741 Bell St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

47

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1872 or 1873

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*abt. 47 yrs**?**?*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Laborer

9 BIRTHPLACE (city or town) (State or country)

Ind.

10 NAME OF FATHER

do not know

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

do not know

12 MAIDEN NAME OF MOTHER

do not know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

do not know

14

Informant (Address)

Mrs. Annie Frame 1741 Bell St.

15

Filed

APR 6 1920

ROBERT A. KAUTER

BRIAL PERMIT 1000

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 15 1920

17

I HEREBY CERTIFY, That I attended deceased from

*April 15, 1920, to April 15, 1920*that I last saw him alive on *April 15, 1920*and that death occurred, on the date stated above, at *1:15 P.M.* m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis with hypertension; cardiac hypertrophy; Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Respiratory paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

1741 Bell St.

Did an operation precede death?

No

Date of

Was there an autopsy?

*No*What test confirmed diagnosis? *Physical and chemical findings*(Signed) *Thurmond P. Alayson*, M. D.*4/15, 1920* (Address) *St. Agnes Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cathedral Cem.**April 17 1920*

20 UNDERTAKER

Margaret L. Flynn

ADDRESS

1422 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42281

CERTIFICATE OF DEATH

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *1447 Lorman* ST. *24* WARD)2-FULL NAME *Mary Shanley*(Residence in Baltimore: No. *1447 Lorman St* St. *24* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE *Single*
 MARRIED
 WIDOWED
 OR DIVORCED
 (Write the word)

6-DATE OF BIRTH *April 5th 1919*
 (Month) (Day) (Year)

7-AGE *1* yrs. mos. ds. or min. ? If LESS than 1 day, hrs.

8-OCCUPATION
 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9-BIRTHPLACE
 (State or country)

Baltimore Md

10-NAME OF FATHER

John Shanley

11-BIRTHPLACE OF FATHER
 (State or country)

Baltimore Md

12-MAIDEN NAME OF MOTHER

Agnes Driscoll

13-BIRTHPLACE OF MOTHER
 (State or country)

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *John Shanley*(Address) *1447 Lorman St*

15-

ROBERT E. KRAUTER

APR 16 1920

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

April 14 1920
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 13 1920*, to, *April 14 1920*, that I saw h^e alive on *April 14 1920*, and that death occurred, on the date stated above, at *7:10 P.* m. The CAUSE OF DEATH* was as follows:

Pneumo Pneumonia(Duration) yrs. mos. ds. *1*

Contributory (SECONDARY)

acute dilatation of heart(Duration) yrs. mos. ds. *2 hours*

(Signed),

Thos F. A. Stearns

M. D.

Apr 14 1920[Address] *2866 Hearford Rd*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Cathedral Cem.

DATE OF BURIAL

April 17 1920

20-UNDERTAKER

M. L. Flynn

ADDRESS

1422 Light St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42282

D42282

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *113 Birchwood Ave* ST. *27* WARD)

2-FULL NAME

(Residence in Baltimore: No. *113 Birchwood Ave.* St. *54* yrs. *0* mos. *22* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *July 24, 1865*
(Month) (Day) (Year)7-AGE, *54 yrs. 8 mos. 22 ds.* If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Machinist*
(b) General nature of industry, business, or establishment in which employed (or employer). *Tin can factory*9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *John D. Jackson*11-BIRTHPLACE OF FATHER, (State or Country), *Baltimore*12-MAIDEN NAME OF MOTHER *Mary J. Konder*13-BIRTHPLACE OF MOTHER, (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles H. Jackson*
(Address) *607 E. Randall St.*

15-

APR 16 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 15, 1920*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Feb 15 1920*, to *April 15 1920*, that I saw him alive on *April 15 1920*, and that death occurred, on the date stated above, at *7:35 P.* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) *2* yrs.mos.ds.

CONTRIBUTORY (Secondary)

(Duration)yrs.mos.ds.

(Signed) *Sidney H. Street* M. D.*Apr 16 1920* (Address) *405 N. Charles St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Westin Cemetery *4/17 1920*

20-UNDERTAKER ADDRESS

C. Dunning & Son 1938 E. Lexington St.

important. See instructions on back of certificate.

D42283

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42283

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 Division

ST.; 14

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Valerika Wheelock

(Residence in Baltimore: No. 1514 Division St.; 2 yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

M.

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH,

May

1915

(Month)

(Day)

(Year)

7-AGE,

4

yrs.

11

mos.

ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Child

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), Tennessee

10-NAME OF FATHER,

Samuel M. Wheelock

11-BIRTHPLACE OF FATHER

(State or Country), Tennessee

12-MAIDEN NAME OF MOTHER

Berrie Bedford

13-BIRTHPLACE OF MOTHER

(State or Country), Tennessee

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Ball

(Address) U. P. 9.

15-

Robert P. Harrison,

APR 16 1920

REGISTERED

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 15

(Month)

(Day)

1920

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mar 30 1920, to April 15 1920,

that I saw him alive on April 15 1920,

and that death occurred, on the date stated above, at 11 Am.

The CAUSE OF DEATH* was as follows:

Tubercular peritonitis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. D. Harrison

M. D.

April 15, 1920. (Address) U. P. 9.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 16 ds. In the State yrs. mos. 16 ds.

Where was disease contracted, if not at place of death? Tennessee

Former or usual residence 201 Maple St. Johnson City Tennessee

19-PLACE OF BURIAL OR REMOVAL,

Johnson City Tenn

DATE OF BURIAL,

April 16, 1920

20-UNDERTAKER

William Cook

ADDRESS

502 E. North Ave

to J. E. Sterchie & Co. Via Adams Express.

D42281

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42281

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 N. 25th ST. 12 WARD)

2-FULL NAME

Elizabeth A. Bowen (Bowen)

(a) RESIDENCE. No.

506 N. 25th St.

ST. 12 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

Life

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Thomas T. Bowen

6 DATE OF BIRTH (month, day, and year)

Feb 19 1898

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

82

1

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Home

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

John Blucher

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Angelina Baker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Md

14

Informant
(Address)Mr. Guyer Kelly
506 N. 25th St.

15

APR 16 1920

Robert F. Harrison,

Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

ST. 12 WARD)

ST. 12 WARD.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 14, 1920, to April 15, 1920,

that I last saw him alive on April 15, 1920,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Fracture of Neck of Femur.
(Old wound broken over
by accident.)

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY Hypertensive Pneumonia

(Secondary)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) R. F. Norman M. D.

4.16.1920 Address 354 Chestnut St

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn

7/17 1920

20 UNDERTAKER

Am Cork

ADDRESS

H. B. M.

N. B.—WRITE PLAINLY, WITH CAPITALS. PHYSICIANS SHOULD STATE EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D42285

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42285

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *404 N. Park* ST.; *6* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Charles Edmund Childsbrand*(Residence in Baltimore: No. *404 N. Park, 116* St.; yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *M*4-COLOR OR RACE. *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *single*6-DATE OF BIRTH, *April 15, 1920*

(Month)

(Day)

(Year)

7-AGE,

yrs. mos. da. *3*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *none*
(b) General nature of industry, business, or establishment in which employed (or employer). *800*9-BIRTHPLACE, (State or Country), *Bath,*

PARENTS.

10-NAME OF FATHER, *August Childsbrand*11-BIRTHPLACE OF FATHER (State or Country), *Bath,*12-MAIDEN NAME OF MOTHER, *Gertrude B. Berg*13-BIRTHPLACE OF MOTHER (State or Country), *Mass,*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Aug. Childsbrand*(Address) *404 N. Park St.*

15-

APR 16 1920

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 15, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 12, 1920*, to *April 15, 1920*,that I saw him alive on *April 12, 1920*,and that death occurred, on the date stated above, at *12 P. m.*

The CAUSE OF DEATH* was as follows:

Premature Birth
seven & half months

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) *conventional*

(Duration) yrs. mos. da.

(Signed) *A. G. Hearn* M. D.*7/16*, 191*20* (Address) *2600 E. Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cathedral Cemetery*DATE OF BURIAL, *April 17, 1920*20-UNDERTAKER *Mrs. C. Miller*ADDRESS *2334 Jefferson St.*

CAUSE OF DEATH. See instructions on back of certificate.

D42286

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42286

CERTIFICATE OF DEATH.

151

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *507 Welling*)ST.: *13* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Infant of Mrs C. & Mary E Donnell*(a) RESIDENCE. NO. *507 Welling* ST. *13* WARD. *13*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town).
(State or country)*Baltimore Md*10 NAME OF FATHER *Chas C Donnell*11 BIRTHPLACE OF FATHER (city or town).
(State or country)*Virginia*12 MAIDEN NAME OF MOTHER *Mary E Donnell*13 BIRTHPLACE OF MOTHER (city or town).
(State or country)*Maryland*

14

Informant
(Address)*Mary E Donnell**507 Welling St - Johns Hopkins Hospital*

15

Filed

Robert D. Harrison,

Registrar

Municipal Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 13 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*April 13 1920 to April 13 1920*that I last saw him alive on *April 13 1920*and that death occurred, on the date stated above, at *12.50 A.M.*

The CAUSE OF DEATH* was as follows:

Infant Convulsion

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)*Peritonitis*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Childhood Convulsion*

(Signed)

R. B. Nonnen M. D.413, 1920 Address) *3543 Chestnut St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

19

20 UNDERTAKER

ADDRESS

Robert D. Harrison

APR 15 1920

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates.

APR 16 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42287

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Johns Hopkins Hospital

ST.: 17 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mr. Theodore Newton Sall

(a) RESIDENCE. NO.

50 West 59th St. N.Y.

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mrs. Mabel Sall

6 DATE OF BIRTH (month, day, and year)

2, 1845

7 AGE

75

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Chairman American Tel. Co.

(b) General nature of industry, business, or establishment in which employed (or employer)

Telephone Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Harristown

N. J.

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

2.

12 MAIDEN NAME OF MOTHER

2.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

2.

14

Informant (Address)

2. 478. Records

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-16 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 11 - 1920, to April 16, 1920,

that I last saw him alive on April 16, 1920,

and that death occurred, on the date stated above, at 5:52 a.m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiency
Pneumonia?

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Prostatic Hypertrophy
renal insufficiency

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No tests.

(Signed)

W. L. Cecil (M.D.)

, 19

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Harristown N. J.

April 17 1920

20 UNDERTAKER

ADDRESS

J. Ahrens & Co

221 N. Broad

Way

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

APR 16 1920

D42288

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42288

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Nevins(a) RESIDENCE. NO. 730 E. Pratt St. ST., Unknown WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
71				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) New York
(State or country) New York10 NAME OF FATHER Owen Nevins11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)12 MAIDEN NAME OF MOTHER Ann Mylady13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)14 Informant Hospital Records
(Address) M.T.H.15 Robert F. Harrison,

APR 16 1920

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 10, 192017 I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1919, to Apr. 10, 1920,
that I last saw him alive on Apr. 9, 1920,
and that death occurred, on the date stated above, at 6:55 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 9 yrs. 9 mos. 9 ds.CONTRIBUTORY
(Secondary)(duration) 9 yrs. 9 mos. 9 ds.18 Where was disease contracted Unknown
if not at place of death?Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum.(Signed) George R. Wilkinson, M. D.4-10-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Poughkeepsie N.Y. Apr. 16 192020 UNDERTAKER
STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.Haugh passenger in charge E. 2620 St Paul St
Balto Md.

CAUSE OF DEATH in plain terms, so that it can be read by the layman. See instructions on back of certificates.

D42289

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42289

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2337 E. Fayette* ST.: *6* WARD)2-FULL NAME *Layton L. Lozon*(a) RESIDENCE. NO. *2337 E. Fayette* ST.: *6* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. *1* mos. *21* ds. How long in U. S., if of foreign birth? *life* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

*Married*5a If married, widowed, or divorced HUSBAND of *Helena Lozon*6 DATE OF BIRTH (month, day, and year) *2/26/90*

7 AGE

30 Years*1* Months*21* Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Claim

(b) General nature of industry, business, or establishment in which employed (or employer)

Adjuster

(c) Name of employer

B & O R. R.

9 BIRTHPLACE (city or town) (State or country)

City

10 NAME OF FATHER

Louis Lozon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant

(Address)

Helena Lozon
2337 E. Fayette St.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 16* 19 *20*

17

I HEREBY CERTIFY. That I attended deceased from

Apr 15, 19 *20*, to *Apr 16*, 19 *20*,that I last saw him alive on *Apr 15*, 19 *20*,and that death occurred, on the date stated above, at *7:30 A.*, m.

The CAUSE OF DEATH* was as follows:

Dysentery (Septic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

*unknown*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

B. H. Meyer Jr.

M. D.

4/16, 1920 (Address)

7638 E. Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Philip Henry's

ADDRESS

2016 Orleans

APR 16 1920

Registrar

Robert F. Harrison

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

D42290

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42290

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Perry(a) RESIDENCE. NO. 37 Baltimore Ave., St. Helena WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown6 DATE OF BIRTH (month, day, and year) 18937 AGE Years Months Days If LESS than 1 day, hrs. or min. 27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland10 NAME OF FATHER John Macby11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)12 MAIDEN NAME OF MOTHER Margaret Connolly13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)14 Informant Hospital Records (Address) M.T.H.15 Filed Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15, 1920

17

I HEREBY CERTIFY, That I attended deceased from March 16, 19 20, to April 15, 19 20,that I last saw h. or alive on April 14, 19 20,and that death occurred, on the date stated above, at 9.05 a.m.

The CAUSE OF DEATH* was as follows:

Haemolytic Strept. coccus Endo-carditis—(duration) 3 yrs. 7 mos. ds.CONTRIBUTORY Diarrhoeal Pneumonia (Secondary) Terminal (duration) 7 yrs. 7 mos. ds.18 Where was disease contracted Unknown If not at place of death?Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum.(Signed) George R. Wilkinson, M. D.-15-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Lawn Cemetery4/17/ 1920

20 UNDERTAKER

ADDRESS 3000J. A. Moran8000

CAUSE OF DEATH is very important. See instructions on back of certificates.

APR 16 1920

APR 16 1920

D42291

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42291

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

211 W. Hamburg

ST.: 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Herbert Spriggs

(a) RESIDENCE. NO.

211 W. Hamburg

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M-

4 COLOR OR RACE

Color.

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 16, 1919.

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Joseph Spriggs

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Lottie Pinkney

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Lottie Spriggs
211 W. Hamburg St

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/16/1920

17

I HEREBY CERTIFY, That I attended deceased from

March 31st, 1920, to April 16th, 1920,that I last saw him alive on April 15th, 1920,

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

malnutrition (duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

no exceptions

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

clinical

(Signed)

Phyllis Bowley

M. D.

4/14/1920

(Address)

908 S. Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel St

April 17, 1920

20 UNDERTAKER

J. H. Brown & Son

108 W. Monte

CAUSE OF DEATH IN plain terms, so that it may be properly classified. See instructions on back of certificates.

APR 17 1920

D42292

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42292

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *852 Powers* ST.: *13* WARD)2-FULL NAME *Victoria Tinker*(a) RESIDENCE. No. *852 Powers* ST. WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1* yrs. *6* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of *✓*6 DATE OF BIRTH (month, day, and year) *Sept 30 1918*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.8 OCCUPATION OF DECEASED *Child*

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*
(State or country)10 NAME OF FATHER *John Tinker*11 BIRTHPLACE OF FATHER (city or town) *MD*
(State or country)12 MAIDEN NAME OF MOTHER *Snelling*13 BIRTHPLACE OF MOTHER (city or town) *MD*
(State or country)

14

Informant
(Address) *P. E. Tinker*
852 Powers St

APR 17 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 15 1920*

17

I HEREBY CERTIFY, That I attended deceased from

April 10 1920, to April 14 1920,
that I last saw him alive on *April 15 1920,*and that death occurred, on the date stated above, at *8 P. m.*
The CAUSE OF DEATH* was as follows:*Illness - Cancer*

(duration)

yrs.

mos.

ds. *30*CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *no*Date of *✓*Was there an autopsy? *no*What test confirmed diagnosis? *no*(Signed) *Dr. G. L. L. L.*

M. D.

1920 (Address) *N. 27 W. 100 St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St Marys Hospital *Apr 17 1920*
Chenoweth Son Chestnut

D42293

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42293

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3642 Roland Ave ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George R Phillips(a) RESIDENCE. NO. 3642 Roland Ave ST. 3 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓6 DATE OF BIRTH (month, day, and year) April 6 18977 AGE Years 23 Months 7 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 186

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind (State or country)10 NAME OF FATHER Wm C Phillips11 BIRTHPLACE OF FATHER (city or town) Ind (State or country)12 MAIDEN NAME OF MOTHER Elizabeth Thauk13 BIRTHPLACE OF MOTHER (city or town) Ind (State or country)14 Informant George Phillips (Address) 3642 Roland Ave

15 Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 192017 I HEREBY CERTIFY, That I attended deceased from Mar 30, 1920, to April 16, 1920.that I last saw him alive on April 3, 1920.and that death occurred, on the date stated above, at 630 a.m.

The CAUSE OF DEATH* was as follows:

Enteritis (Tubercular)
Chronic Pulmonary

CONTRIBUTORY (Secondary)

(duration) yrs. 11 mos. ds.18 Where was disease contracted U.S. Army if not at place of death?Did an operation precede death? No Date of +Was there an autopsy? NoWhat test confirmed diagnosis? Tubercle Bacilli in Sputum(Signed) Harry C. Alsop, M. D.19 (Address) 3642 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden DATE OF BURIAL April 19 192020 UNDERTAKER Chunoweth Son Chestnut

APR 17 1920

D42291

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42291

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2458 Druid Hill Ave 13

2-FULL NAME John Phillip Gordon Tyson

(a) RESIDENCE NO. 2458 Druid Hill Ave

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 8

mos.

ds. How long in U. S., if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD. Orange Va.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar 17, 1919

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

1 0 29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Orange Va

10 NAME OF FATHER

James Tyson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Radcliffe England

12 MAIDEN NAME OF MOTHER

Elizabeth Duckett

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Fiskeville England

14

Informant (Address)

James Tyson 2458 Druid Hill

15

APR 17 1920

Robert F. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15 1920

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1920, to April 15, 1920, that I last saw him alive on April 15, 1920, and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration)

yrs.

mos. 8

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edgar Friedemann, M. D.

Apr 16 1920 (Address) 1616 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Elm

April 17 1920

20 UNDERTAKER

ADDRESS

Wm J. Kuehn

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D42295

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42295

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Marshall Hospital* ST. *11* WARD)FULL NAME *Ruth Ritter*(Residence in Baltimore: No. *108 W Mt Royal ave*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *4* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

7-16-1911
(Month) (Day) (Year)

7-AGE,

9 yrs. 2 mos. 12 ds.

IF LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*School**ooo*9-BIRTHPLACE,
(State or Country),*Va.*

10-NAME OF FATHER,

*Eugene Ritter*11-BIRTHPLACE OF FATHER
(State or Country),*Va.*

12-MAIDEN NAME OF MOTHER

*Blanche Wakley*13-BIRTHPLACE OF MOTHER
(State or Country),*Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Blanche Ritter*(Address) *108 W Mt Royal ave*

15-

Robert P. Harrison,

APR 17 1920

191

Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 14, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)

And that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull struck by Automobile

(Duration) yrs. mos. ds.

CONTRIBUTORY *Accident*
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. J. Gossard* M. D.
(Coroner.)*4-16-1920* (Address) *117 W Saratoga St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Winchester Va.*

19-PLACE OF BURIAL OR REMOVAL,

Woodlawn Cem

DATE OF BURIAL,

April 20, 1920

20-UNDERTAKER

W. J. Tucker

ADDRESS

Wethers

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION if very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D42296

CERTIFICATE OF DEATH.

64

D42296

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. *Andrew J. Reeder*ST.: *11*

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *University Hospital*(a) RESIDENCE. No. *381 Dolphin St.*

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

77 yrs.

11 mos.

29 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

Male

4 COLOR OR RACE

*White*5 Single, Married, Widowed,
or Divorced (write the word)*Married*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Anna H. Hough*

6 DATE OF BIRTH (month, day, and year)

April 19th 1847

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*77**1**11**29*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Retired Coal Merchant*(b) General nature of industry,
business, or establishment in
which employed (or employer)*045*

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Balto. Ind.*

10 NAME OF FATHER

*Charles Reeder*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Balto. Ind.*

12 MAIDEN NAME OF MOTHER

*Frances M. Sherlock*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Balto. Ind.*

14

Informant
(Address)*University Hospital
Lombard Green*

16 DATE OF DEATH (month, day, and year)

April 16 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 14, 19*20*, to *April 16*, 19*20*,that I last saw him alive on *April 16*, 19*20*,and that death occurred, on the date stated above, at *6⁰¹ A* m.

The CAUSE OF DEATH* was as follows:

*Cerebral Apoplexy
Hypertension*(duration) yrs. mos. *2* ds.CONTRIBUTORY
(Secondary)*Myocardial Insufficiency*(duration) yrs. mos. *1* ds.18 Where was disease contracted
If not at place of death?*Attacked on Street*

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

W. Meyer

M. D.

19 (Address)

*University Hospital**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Druid Ridge**April 19 1920*

20 UNDERTAKER

Henry W. Jenkins & Sons Co

ADDRESS

*Orchard
McCulloch*

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificates.

APR 17 1920

Robert P. Harrison Registrar

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42297

D42297

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

Baltimore Md

ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mrs. Katherine Bilz

(Residence in Baltimore: No.

1026 Stirling St.

St.; 37 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, *Mar.*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

Feb 2 20

1868

(Month)

(Day)

(Year)

7-AGE,

52 yrs. 2 mos. 14 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

037

9-BIRTHPLACE,

(State or Country),

Germany

10-NAME OF FATHER,

Adam Hohenberger

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

not known

13-BIRTHPLACE OF MOTHER

(State or Country),

not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Conrad K. Bilz

(Address)

1026 Stirling St.

15-

APR 17 1920

Robert P. Harrison,

191.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 16

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 11 1920, to April 16 1920,

that I saw him alive on April 16, 1920,

and that death occurred, on the date stated above, at 7:30 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Infection of left hand

(Duration) ... yrs. ... mos. ... ds.

(Signed)

Charles J. Kier M. D.

4-16 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 5 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1026 Stirling St.

Former or usual residence 1026 Stirling St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer Cemetery

Apr. 19 1920

20-UNDERTAKER

ADDRESS

Henry Stockman

1301 E. Eager St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42298

CERTIFICATE OF DEATH.

79
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

2020 Eutan Place ST. 14 WARD)

2-FULL NAME

Henry Grinsfelder

(a) RESIDENCE. NO.

2020 E. Place ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth

Sept 1919

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

Florence H. Grinsfelder

6 DATE OF BIRTH (month, day, and year)

July 13/1862

7 AGE

58

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Wholesale

(b) General nature of industry, business, or establishment in which employed (or employer)

Millinery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Joseph Grinsfelder

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Frances Kider

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

H. Grinsfelder

15

Filed

Robert D. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1920

17

I HEREBY CERTIFY, That I attended deceased from March 5, 1920, to April 16, 1920, that I last saw him alive on April 16, 1920, and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 5 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

Oedema of lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Julius Friedman, M. D.

(Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore

April 18 1920

20 UNDERTAKER

ADDRESS

L. J. Bondheum

TION is very important. See instructions on back of certificates.

APR 17 1920

Burial Permit

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42299

D42299

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1336 Penna Ave, ST.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1336 Penna Ave St.; 22 yrs., 22 mos., 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. Caucas 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)6-DATE OF BIRTH. January, 1898
(Month) (Day) (Year)7-AGE. 22 yrs., 22 mos., 22 ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Domestic
(b) General nature of industry, business, or establishment in which employed (or employer). 0709-BIRTHPLACE, (State or Country), Baltimore Md10-NAME OF FATHER, Harry Wilmore11-BIRTHPLACE OF FATHER (State or Country), Charles Co. Md.12-MAIDEN NAME OF MOTHER Wm. Korman13-BIRTHPLACE OF MOTHER (State or Country), 4 4

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles H. Gross(Address) 1336 Penna Ave

15-

APR 17 1920 Robert P. Harrison,

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. April 14, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Feb 15, 1920, to April 14, 1920, that I saw her alive on Apr 14, 1920, and that death occurred, on the date stated above, at 11 A. m. The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
(Duration) 2 yrs., 2 mos., 22 ds.CONTRIBUTORY
(Secondary)(Signed) T. E. Laughery M. D.
Apr 15, 1920 (Address) 1602 Penna Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. 22 yrs., 22 mos., 22 ds. In the State 22 yrs., 22 mos., 22 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Int. Burial Society 4/17, 1920

20-UNDERTAKER

ADDRESS

Mrs. H. H. Hays 1602 Penna Ave

Important. See instructions on back of certificate.

D42300

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42300

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 634 Belvidere Ave. ST. 26 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 634 Belvidere Ave.

(Usual place of abode)

ST. WARD.

Length of residence in city or town where death occurred

55 yrs. 4 mos.

ds.

How long in U. S., if of foreign birth?

Life yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 18 1866

7 AGE

Years

55

Months

4

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md

10 NAME OF FATHER

Edw. M. Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md

12 MAIDEN NAME OF MOTHER

Catherine Goldsmith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Chas. E. Dorsey 634 Belvidere Ave.

15

Medical Officer

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 16 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr 15 1920 to Apr 16 1920.

that I last saw him live on Apr 16 1920.

and that death occurred, on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Daniel Brown, M. D.

, 19 (Address) 1837 Pa. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cem

April 19 1920

20 UNDERTAKER

ADDRESS

John J. Conner & Son 901 Hollins St

CAUSE OF DEATH is very important. See instructions on back of certificates.

APR 17 1920

D42301

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42301

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. Elkridge Rd ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos. 1 4 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day 1 4 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)10 NAME OF FATHER Ray Shilling11 BIRTHPLACE OF FATHER (city or town) Washington
(State or country) D.C.12 MAIDEN NAME OF MOTHER Betsy Jones13 BIRTHPLACE OF MOTHER (city or town) Washington
(State or country) D.C.

14

Informant
(Address)Robert P. Garrison

APR 7 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 19 2017 I HEREBY CERTIFY, That I attended deceased from Apr 16, 19 20, to Apr 16, 19 20, that I last saw him alive on Apr 16, 19 20, and that death occurred, on the date stated above, at 1 P m.
The CAUSE OF DEATH* was as follows:CONTRIBUTORY
(Secondary)(duration) yrs. 6 mos. ds.(duration) yrs. mos. 1 4 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Phys. signs(Signed) Dr. Freeman, M. D., 19 (Address) 2031 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Domina Sener Health,

ADDRESS

APR 17 1920

D42302

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42302

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Strophs 7th ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. Elkridge Ind ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

3 3/4

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

CAUSE OF DEATH is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 19 20

17

I HEREBY CERTIFY, That I attended deceased from
Apr 16, 19 20, to Apr 16, 19 20,
that I last saw him alive on Apr 16, 19 20,
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:CONTRIBUTORY
(Secondary)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? phys. signs(Signed) Dr. T. M. Luman, M. D., 19 (Address) 2651 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Commissioner Health.

APR 17 1920

Burial Permit Clerk.

Registrar

APR 17 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *14* ST.; *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St Vincent Asylum* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

April 11, 19*22*
(Month) (Day) (Year)

7-AGE,

4 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer) *none*9-BIRTHPLACE, (State or Country), *Baltimore Md*10-NAME OF FATHER, *unknown*11-BIRTHPLACE OF FATHER (State or Country), *unknown*12-MAIDEN NAME OF MOTHER *Bertie Harrison*13-BIRTHPLACE OF MOTHER (State or Country), *Delaware*

14-THIS ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Bertie Harrison*(Address) *St Vincent Asylum*

15-

Robert P. Harrison;

APR 19 1922

Burial Permit *Clark*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 13, 19*22*
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *April 12* 19*22*, to *April 13* 19*22*, that I saw him alive on *April 13* 19*22*, and that death occurred, on the date stated above, at *2 P.* m.

The CAUSE OF DEATH* was as follows:

Gastroenteritis
(Duration) yrs. mos. ds. *2* ds.

CONTRIBUTORY (Secondary)

(Signed) *Chas. H. Chandler* M. D.
April 13, 19*22* (Address) *1502 W. North*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral

DATE OF BURIAL,

April 19, 19*22*

20-UNDERTAKER

M. Fahy - Son 1827 W North

ADDRESS

D42304

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

South Balto. Gen'l Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

1213 Light

ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Bey Ford

(Residence in Baltimore: No.

216 E. Montgomery

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

White

5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

April 12, 1920
(Month) (Day) (Year)

7-AGE,

yrs. mos. 3 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country),

Baltimore, Md.

PARENTS.

10-NAME OF FATHER,

Luther B Ford

11-BIRTHPLACE OF FATHER

(State or Country),

Pa

12-MAIDEN NAME OF MOTHER

Grace D Howard

13-BIRTHPLACE OF MOTHER

(State or Country),

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Lawson

(Address)

216 E. Montgomery St

15-

Robert P. Harrison

PRI 7 1920

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

4 - 16, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

4 - 12 1920, to 4 - 16 1920,

that I saw him alive on 4 - 16 1920,

and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

1- Congenital atelectasis

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. R. Reynolds M. D.

4 - 16, 1920 (Address) 1213 Light St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 3 ds. In the State yrs. mos. 3 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn

PLACE OF BURIAL,

APR 17 1920

20-UNDERTAKER

John P. Denny

ADDRESS

715 Light St

D42305

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42305

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *707 George* St.; *17* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Lizzie J. Kane*(Residence in Baltimore: No. *707 George* St.; *67* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Colored

5-SINGLE

Widow
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

Nov 7, 1857
(Month) (Day) (Year)

7-AGE.

62 yrs. *5* mos. *7* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Housekeeper*9-BIRTHPLACE,
(State or Country),*Ind*

10-NAME OF FATHER,

Wm H. Smith

11-BIRTHPLACE OF FATHER

(State or Country),

Ind

12-MAIDEN NAME OF MOTHER

Emma J. Smith

13-BIRTHPLACE OF MOTHER

(State or Country),

Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Taylor*(Address) *707 George St*

15-

Robert P. Harrison,

191.

Registrar.

Burial Permit Clerk,

APR 17 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr 14, 1920
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Mar 14, 1920* to *Apr 14, 1920*, that I saw her alive on *Apr 14, 1920*, and that death occurred, on the date stated above, at *5:15 P.* m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Dr. J. Carr* M. D.*Apr 16, 1920* (Address) *515 Mosby St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

*Laurel Cemetery**Apr 17, 1920*

20-UNDERTAKER

ADDRESS

*George H. Holland**1631 Druid Hill ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42306

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Herman Giele*(a) RESIDENCE. NO. *1412 E 109th St. Cleveland Ohio* WARD. *12th Cleveland O.*
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*5a If married, widowed, or divorced
HUSBAND of *Widowed*
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *May 2-1863*7 AGE *66* Years *11* Months *15* Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Supt. of Foundry*(b) General nature of industry, business, or establishment in which employed (or employer) *286*

(c) Name of employer

9 BIRTHPLACE (city or town, State or country) *Germany*10 NAME OF FATHER *Herman Giele*11 BIRTHPLACE OF FATHER (city or town, State or country) *Hannover Germany*12 MAIDEN NAME OF MOTHER *F. Samman*13 BIRTHPLACE OF MOTHER (city or town, State or country) *Hannover Germany*14 Informant *Hospital Record*
(Address) *286*15 *Robert P. Harrison* Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 17 1920*17 I HEREBY CERTIFY, That I attended deceased from *April 10th*, 1920, to *April 17*, 1920, that I last saw him alive on *April 17*, 1920, and that death occurred, on the date stated above, at *2:25 a.m.*
The CAUSE OF DEATH* was as follows:
*Carcinoma Stomach*CONTRIBUTORY (Secondary) *Operation:* (duration) yrs. 2 mos. ds.18 Where was disease contracted if not at place of death? *Cleveland*Did an operation precede death? *yes* Date of *Apr. 13, 1920*Was there an autopsy? *yes*What test confirmed diagnosis? *Pathological*(Signed) *Wm. R. Reed* M. D.19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Cleveland Ohio* DATE OF BURIAL *April 17 1920*20 UNDERTAKER *H. E. Hughes* ADDRESS *17 St. Broadway*

CAUSE OF DEATH in plain language is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42307

D42307

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 Light

ST.: 73 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 1310 Light

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs.

ST.: 73 WARD.
(If nonresident give city or town and State)
How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

PARENTS

14 Informant
(Address)

APR 17 1920

Robert P. Harrison,
Registrar
Daniel Fernit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1920

17 I HEREBY CERTIFY, That I attended deceased from
Mon 26 1920 to April 15 1920
that I last saw him alive on April 15 1920
and that death occurred, on the date stated above, at 6:00 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. J. F. H. M. D.

19 (Address) 2082 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

2 UNDER TAKER

ADDRESS

D42308

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42308

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 S. Smallwood St. ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Dunkerly(a) RESIDENCE. No. 425 S. Smallwood St. ST. 20 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 9 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) June 25, 19027 AGE Years Months Days If LESS than 1 day, hrs. or min.
17 9 21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Piston Ring Dept.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer H. & B. Co.9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland.10 NAME OF FATHER Louis Dunkerly11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland12 MAIDEN NAME OF MOTHER Lena Hoffman13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.14 Informant Mrs. Lena Dunkerly
(Address) 425 S. Smallwood St.15 Filled Robert F. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-16 1920

17

I HEREBY CERTIFY, That I attended deceased from Jan 22, 1920, to April 16, 1920,
that I last saw her alive on April 15, 1920,
and that death occurred, on the date stated above, at 4 30 a m.
The CAUSE OF DEATH* was as follows:Pulmonary TuberculosisCONTRIBUTORY
(Secondary)18 Where was disease contracted
If not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert C. Hutchins M. D.Apr 17 1920 (Address) 2451 Sullivan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral CemApr 19 1920

20 UNDERTAKER

ADDRESS

Joseph B. Cook10034 Balto St

TION is very important. See instructions on back of certificates.

APR 17 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C. 42309

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 WARD)

2-FULL NAME

(Residence in Baltimore: No. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widowed (Write the word.)

6-DATE OF BIRTH, October 13, 1831. (Month) (Day) (Year)

7-AGE, 88 yrs. 8 mos. 10 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Wine merchant (b) General nature of industry, business, or establishment in which employed (or employer), 045

9-BIRTHPLACE, (State or Country), Virginia

10-NAME OF FATHER, Joseph S. Johnson

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Ann Hickman

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Muriel Seckins

(Address) Greenwood Apts.

15-APRIL 7 1920 Robert P. Harrison, Registrar

Filed April 11, 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 15, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 13, 1920, to April 13, 1920, that I saw him alive on April 10, 1920, and that death occurred, on the date stated above, at 5 p. m. The CAUSE OF DEATH* was as follows:

Heart Block Instantly (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Infarction

(Signed) M. D. 4/17, 1920 (Address) 6 E. Read St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, London Park April 17, 1920

20-UNDERTAKER, J. O. Mitchell 1201 N. Fayette St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42310

D42310

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE

2-FULL NAME

(a) RESIDENCE

(Usual place of abode)

Length of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)14 Informant
(Address)

15

APR 18 1920

ROBERT E. EBAUTER
Registrar

Serial 1000000

WARD)

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth?

yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That attended deceased from
April 12, 1920, to April 16, 1920,
that I last saw him alive on April 16, 1920,
and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial
NephritisCONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNDERSEALER

D42311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

D42311

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1357 Woodys St.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mamie E. Spriggs

(Residence in Baltimore: No. 1357 Woodys St.; yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Caucasian

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH

April 8th 1919 (Month) (Day) (Year)

7-AGE,

1

yrs. 8 mos. da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

Child 100

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Joseph Spriggs

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Mamie Ruders

13-BIRTHPLACE OF MOTHER (State or Country),

Ches., Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joseph Spriggs

(Address)

1357 Woodys St.

15-

APR 18 1920

ROBERT R. KRAUTER

Filed....., 191.

Burial in the

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 17th 1920 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

April 16th 1920, to April 17th 1920,

that I saw him alive on April 16th 1920,

and that death occurred, on the date stated above at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration).....yrs.....mos.....da.

CONTRIBUTORY..... (Secondary).....

(Duration).....yrs.....mos.....da.

(Signed)..... M. D.

April 17th 1920 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the.....yrs.....mos.....da. State.....

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt. Auburn April 19th 1920

20-UNDERTAKER ADDRESS

Samuel Wright 1364 Maryland

important. See instructions on back of certificate.

D42312

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42312

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Betty Brown(a) RESIDENCE. No. 922 Leadenhall St.

ST. _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
54				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) Virginia
(State or country)10 NAME OF FATHER Adam William11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)14 Informant Hospital Records(Address) New City Hospital.15 File APR 18 1920 ROBERT H. KRAUTER
Registrar

Barrat Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 1920

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1920, to April 16, 1920, that I last saw her alive on April 15, 1920, and that death occurred, on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes mellitusCONTRIBUTORY
(Secondary)(duration) ? yrs. _____ mos. _____ ds.(duration) _____ yrs. _____ mos. 10 ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) W. B. Stevenson M. D.Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

W. B. Stevenson4/18/20

20 UNDERTAKER

ADDRESS

Geo. A. Trudman 48 W. Hill

CAUSE OF DEATH. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42313

CERTIFICATE OF DEATH.

120
REGISTERED NO. C

D42313

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *mt vicars* ST.; *27* WARD)

2-FULL NAME

(Residence in Baltimore: No. *Center and Ridge Sts mt vicars* St.; *49* yrs. *8* mos. *19* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *female* 4-COLOR OR RACE, *col.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*6-DATE OF BIRTH, *Dec.* *28*, *1870*
(Month) (Day) (Year)7-AGE, *49* yrs. *8* mos. *19* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Housework.*
(b) General nature of industry, business, or establishment in which employed (or employer) *037*9-BIRTHPLACE,
(State or Country), *md.*10-NAME OF FATHER, *George Collins*11-BIRTHPLACE OF FATHER (State or Country), *md.*12-MAIDEN NAME OF MOTHER *Sarah Sawyer*13-BIRTHPLACE OF MOTHER (State or Country), *md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William Logan*(Address) *mt vicars*

15-

APR 18 1920

ROBERT B. KRAUTH

Filed

191

REGISTERED

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April* *15*, *1920*
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *Nov* 1919, to *April 15* 1920, that I saw her alive on *April 12* 1920, and that death occurred, on the date stated above, at *11 p.* m. The CAUSE OF DEATH* was as follows:*Bright's Disease*
(Duration) *1* yrs. *1* mos. *1* ds.CONTRIBUTORY *Heart Disease*
(Secondary)(Duration) *1* yrs. *1* mos. *1* ds.(Signed) *R. C. M. D.**April 16, 1920* (Address) *Center and Ridge Sts*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

142 Auburn Ave *4/15/20*

20-UNDERTAKER

ADDRESS

J. H. Jordan *142 W. Hill*

D42314

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D42314
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1302 Myrtle Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1302 Myrtle Ave St. 17 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)6-DATE OF BIRTH, 4 15, 1920
(Month) (Day) (Year)7-AGE, 7 yrs., 7 mos., 7 ds. If LESS than 1 day, 10 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Maryland10-NAME OF FATHER, Sam Amos11-BIRTHPLACE OF FATHER (State or Country), Virginia12-MAIDEN NAME OF MOTHER, Annie Bevens13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam Amos(Address) 1302 Myrtle Ave

15-

APR 18 1920

ROBERT R. KAUTER

Filed, 191

Serial Permit Required

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 15, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from 4-15-1920 191, to 4-15-1920 191, that I saw her alive on 4-15-1920 191, and that death occurred, on the date stated above, at 7:00 m.

The CAUSE OF DEATH* was as follows:

Prematurely born in 6th month

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John B. ... M. D.4-16-20, 191... (Address) 714 W. Lafayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Luke'sDATE OF BURIAL, Apr 18, 192020-UNDERTAKER, Samuel H. ...ADDRESS, 58th St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42315

CERTIFICATE OF DEATH.

92 D42315

PLACE OF DEATH

CITY OF BALTIMORE (No. *105 W. Biddle* ST. *17* WARD)

2-FULL NAME

Melvin Corbin(Residence in Baltimore: No. *105 W. Biddle St.* St.; yr. *Life* mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

July 14, 1919
(Month) (Day) (Year)

7-AGE,

1 yrs. *7* mos. *7* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none
000

9-BIRTHPLACE,

(State or Country),

md

10-NAME OF FATHER,

Jas. Lindsey

11-BIRTHPLACE OF FATHER

(State or Country),

va

12-MAIDEN NAME OF MOTHER

Rosa Corbin

13-BIRTHPLACE OF MOTHER

(State or Country),

va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Rosa Corbin

(Address)

105 W Biddle St

15-

APR 18 1920

ROBERT R. KAUTER

Filed

191

Burial Per (Registrar)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr 16, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest*
(Inquest, au-*inquest* find that said deceased came to death
topsy or inquiry
on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *F. E. Smith* M. D.

(Coroner)

Apr 17, 1920 Address *908 S. 1st St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Ambrose *Apr 18 1920*

20-UNDERTAKER

ADDRESS

Samuel Hendry *578 W Biddle*

CAUSE OF DEATH in plain terms, so that it may be easily understood. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42316

CERTIFICATE OF DEATH.

151

D42316

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 653 GeorgeST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Hunt(a) RESIDENCE. NO. 653 GeorgeST.: 17 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos. 21

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)FemaleCol.Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) March 25/20

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)12 MAIDEN NAME OF MOTHER Naomi Green13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

APR 8 1920

ROBERT H. KRAUTER

Burial Permit 0189

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 19 20

17

I HEREBY CERTIFY, That I attended deceased from
April 12, 19 20, to April 15, 19 20,
that I last saw him alive on April 14, 19 20,
and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration)

yrs.

mos. 21

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos. 4

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

4/17, 1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

D42318

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

61-001 D42318

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 Calvert

ST.: 11

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Hopkins Boyle

(a) RESIDENCE. NO. 1123 N. Calvert

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 29, 1914

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.~~1914~~

5

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore, Md.

10 NAME OF FATHER

Heyward S. Boyle

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Amabel Lee George

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Baltimore, Md.

14 Informant
(Address)W. J. Jenkins, Son
Baltimore, Md.

15 Filed

APR 18 1920

ROBERT I. LAUTER
Registrar

Barclay Parrott Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 7, 1920, to April 17, 1920,

that I last saw him alive on April 17, 1920,

and that death occurred, on the date stated above, at 4:10 p. m.

The CAUSE OF DEATH* was as follows:

Acute Cerebro Spinal
Meningitis.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis Exam. of Spinal fluid

(Signed) S. Carroll Lockard, M. D.

, 19 (Address)

43 Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery April 18 1920

20 UNDERTAKER

ADDRESS

Henry H. Jenkins, Son Co. No. 60 Collopy

D42319

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42319

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1137 Redgely* ST.; *21* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Samuel Walter Jenkins*(Residence in Baltimore: No. *1137 Redgely St.* St.; *40* yrs. *10* mos. *20* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Male</i>	4-COLOR OR RACE, <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <i>married</i> (Write the word.)
6-DATE OF BIRTH, <i>March 16, 1890</i> (Month) (Day) (Year)		
7-AGE, <i>40</i> yrs. <i>10</i> mos. <i>30</i> ds. If LESS than 1 day,hrs. or....min.?		

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Steam fitter*
(b) General nature of industry, business, or establishment in which employed (or employer). *060*

9-BIRTHPLACE,
(State or Country), *Ind.*

PARENTS.	10-NAME OF FATHER, <i>Samuel W. Jenkins Sr.</i>
	11-BIRTHPLACE OF FATHER (State or Country), <i>Ind.</i>
	12-MAIDEN NAME OF MOTHER, <i>Catherine Sharkey</i>
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Ind.</i>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Gertrude Jenkins*(Address) *1137 Redgely St.*

15-

APR 18 1920 ROBERT M. BAUTER
Filed. 191. *1137 Redgely St.* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 15, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 1, 1920*, to *April 15, 1920*, that I saw him alive on *April 14, 1920*, and that death occurred, on the date stated above, at *10 a. m.* The CAUSE OF DEATH* was as follows:

Spontaneous aneurysm of the aorta
(Duration) *1* yrs. *7* mos. *10* ds.

CONTRIBUTORY (Secondary) *Tuberculosis of the lungs*
(Duration) *6* yrs. *6* mos. *10* ds.

(Signed) *Robert M. Bauter, M. D.*
April 15, 1920 (Address) *1137 Redgely St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *40* yrs. *10* mos. *30* ds. In the State *Ind.* yrs. *10* mos. *30* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. John's Church*DATE OF BURIAL, *Apr. 17, 1920*20-UNDERTAKER, *Geo. W. Schmitt & Co.*ADDRESS *2101 E. McKim*

D42320

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

134 D42320

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2010 Hollins* ST.: *20* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ancie May Bousall(a) RESIDENCE. NO. *2010 Hollins* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F.* 4 COLOR OR RACE *W.* 5 Single, Married, Widowed, or Divorced (write the word) *Divorced*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*George Thompson*6 DATE OF BIRTH (month, day, and year) *Feb 10 - 1894*7 AGE Years *26* Months *2* Days *4* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Md*
(State or country)10 NAME OF FATHER *Chas. Edw. Bousall*11 BIRTHPLACE OF FATHER (city or town) *Balto Co. Md.*
(State or country)12 MAIDEN NAME OF MOTHER *Ella Heil*13 BIRTHPLACE OF MOTHER (city or town) *Balto. Md.*
(State or country)14 Informant *Ella Bousall*
(Address) *2010 Hollins St*15 Filed *APR 18 1920* Registrar *George L. Schwat*
Burial Permit Clerk *Clark*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-14* 19 *20*

I HEREBY CERTIFY, That I attended deceased from

4-14, 19 *20*, to *4-14*, 19 *20*.that I last saw her alive on *4-14*, 19 *20*,and that death occurred, on the date stated above, at *11:50 P.M.*

The CAUSE OF DEATH* was as follows:

Uterine Hemorrhage
Probable miscarriage

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?19 Was an operation precede death? *✓* Date ofWas there an autopsy? *✓*

What test confirmed diagnosis?

(Signed) *E. Heller* *Hemming*, M. D.16, 19 *20* (Address) *2000 Hollins St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park *Apr 19 20*

20 UNDERTAKER ADDRESS

George L. Schwat *2010 Hollins St*

CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* 20 WARD)2-FULL NAME *Walter Levering*(a) RESIDENCE. NO. *Golden Park Cemetery*

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

WARD. *12th*

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec 9-1919*

7 AGE

Years

4 Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.*
(State or country)10 NAME OF FATHER *Walter Levering*11 BIRTHPLACE OF FATHER (city or town) *Md.*

(State or country)

12 MAIDEN NAME OF MOTHER *Grace Horn*13 BIRTHPLACE OF MOTHER (city or town) *Md.*

(State or country)

14

Informant (Address)

15

Hospital Record
J. H. H.
APR 18 1920**ROBERT E. LAUTER**
Registrar

Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 16 1920*17 I HEREBY CERTIFY. That I attended deceased from *April 8th 1920* to *April 16, 1920*, that I last saw him alive on *April 16th 1920*, and that death occurred, on the date stated above, at *4:55 p.m.*

The CAUSE OF DEATH* was as follows:

Acute Myocardial

CONTRIBUTORY (Secondary)

(duration)

2 yrs.

6 mos.

2 ds.

tubercular meningitis

(duration)

yrs.

mos.

17 ds.

18 Where was disease contracted if not at place of death? *Patent home*Did an operation precede death? *20* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *T.B. special fluid*

(Signed)

19 (Address) *1111*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**Apr 19 1920*

20 UNDERTAKER

*Geo. L. Schwaab**Brooklyn*

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

D42322

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42322

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 5802 York Road ST. 27 WARD)

FULL NAME Ella L. Wilson

(Residence in Baltimore: No. 5802 York Road

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. 11 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-STATUS

MARRIED

WIDOWED

OR SEPARATED

(Write the word.)

Widow

6-DATE OF BIRTH

April 28th, 1863

7-AGE

56 yrs. 11 mos. 19 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Homework Home

9-BIRTHPLACE

(State or Country)

Baltimore Md.

10-NAME OF FATHER

John W. Wilson

11-BIRTHPLACE OF FATHER

(State or Country)

Md.

12-MAIDEN NAME OF MOTHER

Leticia Emmart

13-BIRTHPLACE OF MOTHER

(State or Country)

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. H. Wilson

(Address)

5802 York Road

15-

Filed

APR 18 1920

101

ROBERT E. KRAUTER

Bureau of Health Officer

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

April 17, 1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to death on the date stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

John W. Wilson

(Coroner)

(Address)

5832 Redwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL

London Park

DATE OF BURIAL

April 18, 1920

20-UNDERTAKER

Baltimore

ADDRESS

1723 York Road

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42323

CERTIFICATE OF DEATH.

120 D42323

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1734 Clarkson ST. 29 WARD)

2-FULL NAME Charles M. Walter

(a) RESIDENCE. NO. 1734 Clarkson ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4, 1900

7 AGE Years 19 Months 6 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machanic
(b) General nature of industry, business, or establishment in which employed (or employer) Helper
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Charles Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Conie Reinhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Charles M. Walter
1734 Clarkson St.

15 APR 18 1920 ROBERT E. KAUTHE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1920

17 I HEREBY CERTIFY, That I attended deceased from April 1, 19 20, to April 16 19 20, that I last saw him alive on April 16, 19 20, and that death occurred, on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY Uremic Convulsions
(Secondary) (duration) yrs. mos. ds. 2

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis chemically

(Signed) Rich Campbell, M. D.

1920 (Address) 1644 Hancock

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Cross A. A.

20 UNDERTAKER Mrs J. E. Evans

ADDRESS 1428 1/2 Ave

CAUTION is very important. See instructions on back of certificate.

D42324

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42324

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *764 Waverly*)ST.: *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Alberta Pinner

(a) RESIDENCE. NO.

*764 Waverly*ST.: *-* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. ds. How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*-*6 DATE OF BIRTH (month, day, and year) *May 24, 1889*

7 AGE

40

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Household work

(b) General nature of industry, business, or establishment in which employed (or employer)

Servant

(c) Name of employer

Miss Grace Fisher

9 BIRTHPLACE (city or town) (State or country)

Swanton Co. Va.

10 NAME OF FATHER

Harmon Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Payne

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14 Informant (Address)

*Hortense Pinner
764 Waverly St*

15

*APR 18 1920**ROBERT F. KRAUTER**Registrar*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 16 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*Nov 1, 1919, to April 16, 1920*that I last saw her alive on *April 15, 1920*and that death occurred, on the date stated above, at *8:30 A.M.*

The CAUSE OF DEATH* was as follows:

metabolic insufficiency of heart vessels(duration) yrs. *6* mos. ds.

CONTRIBUTORY (Secondary)

Paralysis(duration) yrs. *9* mos. ds.

18 Where was disease contracted

If not at place of death? *-*Did an operation precede death? *No* Date of *-*Was there an autopsy? *No*What test confirmed diagnosis? *-*(Signed) *W. J. Masters*

M. D.

, 19 (Address) *2008 Eastern Place*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*St. Ambrose**APR 18 1920*

20 UNDERTAKER JAMES H. DENNIS ADDRESS

1303 PRESTMAN ST.

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42325

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4334 Ready ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ann E. Griffith

(a) RESIDENCE. NO.

4334 Ready ave ST.: 27 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Albert C. Griffith

6 DATE OF BIRTH (month, day, and year)

Mar. 17-1845

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7510

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Delaware

10 NAME OF FATHER

Jno. Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Delaware

12 MAIDEN NAME OF MOTHER

Mary Samuels

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Delaware

14

Informant (Address)

Mrs. Laura J. Courts
4334 Ready Ave

15

File

APR 18 1920ROBERT A. CRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-17 192017 I HEREBY CERTIFY, That I attended deceased from April 13, 1920, to April 17, 1920, that I last saw her alive on April 16, 1920, and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Fall.
Fracture of Left Hip.(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) H. C. Heers M. D.4-17-1920 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Washington DC4/19 1920

20 UNDERTAKER

ADDRESS

John Cork77 & Me.

CAUSE OF DEATH is very important. See instructions on back of certificates.

D42326

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

32 D42326

1-PLACE OF DEATH

Kernans Hospital

REGISTERED No. C.....

CITY OF BALTIMORE: (No.)

Hillsdale

ST.

WARD) 28

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Lillian M. Leod

(Residence in Baltimore: No.)

Kernans Hosp.

St.; yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

female

4-COLOR OR RACE

white

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

single

6-DATE OF BIRTH

Feb.

(Month)

22

(Day)

1901

(Year)

7-AGE

19

yrs.

1

mos.

25

ds.

or

min.?

If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

school girl

9-BIRTHPLACE

(State or country)

North Carolina

10-NAME OF FATHER

William M. Leod

11-BIRTHPLACE OF FATHER (State or country)

North Carolina

12-MAIDEN NAME OF MOTHER

Nannie Guntie

13-BIRTHPLACE OF MOTHER (State or country)

North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George H. Linn M.D.

(Address)

Hillsdale, Md.

15-

APR 18 1920

ROBERT B. KAUFMAN

SPECIAL PERMIT REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

April

(Month)

17

(Day)

1920

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr. 4, 1919, to, Apr. 17, 1920,

that I saw him alive on Apr. 17, 1920,

and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Spine

(Duration)

2

yrs.

mos.

ds.

Contributory (SECONDARY)

Myocardial Insufficiency

(Duration)

7

yrs.

mos.

ds.

(Signed)

George H. Linn

M. D.

4-17-20, 1919

[Address]

Kernans Hospital

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death 1 yrs. - mos. 13 ds. State 1 yrs. - mos. 13 ds.

Where was disease contracted, If not at place of death? North Carolina

Former or usual residence Greensboro, N. Carolina

19-PLACE OF BURIAL OR REMOVAL

Greensboro N.C.

DATE OF BURIAL

April 19, 1920

20-UNDERTAKER

William Cope

ADDRESS

5028 North

State of Maryland. See instructions on back of certificate. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D42327

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2628 Maier Lane ST. 20 WARD)

2-FULL NAME

(a) RESIDENCE. No. 2628 Maier Lane ST. WARD.

(Usual place of abode)

yrs.

mos. 21 ds.

How long in U. S., if of foreign birth

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Widow of John R. Carter

6 DATE OF BIRTH (month, day, and year) Jan 3 1888

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

32 3 13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Edward Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Mary Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Miss

14

Informant (Address)

Mary Lynch 728 S. Calverton Ave

15

APR 18 1920

ROBERT E. KRAUTH

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1920

17 I HEREBY CERTIFY, That I attended deceased from April 12 1920 to April 16 1920 that I last saw her alive on April 16 1920 and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary) Cardiac Failure (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Relate test

(Signed) Asa F. Wessell, M. D.

Address 2565 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Baltimore April 18 1920

UNDERTAKER W. B. 502 E. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

042328

CERTIFICATE OF DEATH.

79 042328

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Appleton & Resettman St.*)

WARD) *14*

2-FULL NAME

George Saunders.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *581 Resettman*)

St.: (yrs. *21*) mos. *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *color* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married* (Write the word.)

6-DATE OF BIRTH, *unknown*, *1* (Month) (Day) (Year)

7-AGE, *56* yrs. *6* mos. *6* ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Lector* (b) General nature of industry, business, or establishment in which employed (or employer), *086*

9-BIRTHPLACE, (State or Country), *Fredrick md*

10-NAME OF FATHER, *unknown*

11-BIRTHPLACE OF FATHER (State or Country), *md*

12-MAIDEN NAME OF MOTHER, *unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William S. Benedict*

(Address) *Fredrick md*

15. APR 18 1920

Filed *101* *Robert H. Bennett* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Apr. 13, 1920* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest and that said deceased came to death *inquest* topy, or inquiry, on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease (Duration) *6* yrs. *6* mos. *6* ds.

CONTRIBUTORY (Secondary) *7* (Duration) *7* yrs. *6* mos. *6* ds.

(Signed) *J. C. Smith* M. D. (Coroner)

4/17/20 (Address) *910 Light St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death *6* yrs. *6* mos. *6* ds. State *6* yrs. *6* mos. *6* ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Not sent cemetery* DATE OF BURIAL, *4/19*, 19*20*

20-UNDERTAKER *Edw Ringgold* ADDRESS *1463 Carey St*

CAUSE OF DEATH in plain terms. important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42329

CERTIFICATE OF DEATH.

D42329

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST.: *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Caroline Barbara*(a) RESIDENCE. No. *925 N. Rose St.* ST.: *12th* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *21* yrs. — mos. — ds. How long in U. S., if of foreign birth? *21* yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *married*

5a If married, widowed, or divorced

*WIFE of Charles Barbara.*6 DATE OF BIRTH (month, day, and year) *1883*7 AGE *36* Years Months Days *LESS than 1 day, hrs. or min.*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Italy* (State or country)10 NAME OF FATHER *Runcio Bruno*11 BIRTHPLACE OF FATHER (city or town) *Italy* (State or country)12 MAIDEN NAME OF MOTHER *Anna Rosa*13 BIRTHPLACE OF MOTHER (city or town) *Italy* (State or country)14 Informant *Hospital Record* (Address) *H. H.*15 Filed *APR 18, 1920* *ROBERT B. RAUTER* Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 16 1920*17 I HEREBY CERTIFY, That I attended deceased from *April 16th 1920*, to *April 16th 1920*, that I last saw her alive on *April 16th 1920*, and that death occurred, on the date stated above, at *4:55 p.m.*

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency(duration) *6* mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Physical Diagnosis*(Signed) *Ann Phedy* only, M. D., 19 (Address) *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Vincent Cemetery**7/19/ 1920*

20 UNDERTAKER

ADDRESS

George J. Ruth 1735 Hayford Ave.

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42330

CERTIFICATE OF DEATH.

79 D42330

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114. N. Pearl ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Michael E. Bayer

(a) RESIDENCE. NO.

714 N. Pearl St. ST. 4 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar. 1873

7 AGE

47

Years

Months

Days

If LESS than 1 day, hrs. or min.

March

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Basket 086

(b) General nature of industry, business, or establishment in which employed (or employer)

Maker.

(c) Name of employer

J. Reutz
Germany.

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

E. Bayer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany.

12 MAIDEN NAME OF MOTHER

Jacobina Schm.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany.

14

Informant

(Address)

Anna Schmidt
1743 E. Baltimore St.

15

APR 18 1920

ROBERT H. KAUFMAN

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 17 1920

17

I HEREBY CERTIFY, That I attended deceased from April 7-, 1920, to April 17-, 1920, that I last saw him alive on April 16, 1920, and that death occurred, on the date stated above, at 12- m.

The CAUSE OF DEATH* was as follows:

Coronary Dis - Aortic Regurg. et -(duration) yrs. 10 mos. 10 ds.

CONTRIBUTORY (Secondary)

Coronary failure -(duration) yrs. 2 mos. 2 ds.

18 Where was disease contracted if not at place of death?

CityDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? usual(Signed) Robert H. Kaufman, M. D.19/4/1920 (Address) 125 E. Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cemetery April 20 1920

20 UNDERTAKER

ADDRESS

George J. Reutz 1735 Haysford Ave.

D42331

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42331

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Walter B. Jones*(a) RESIDENCE. NO. *Davis Street* *Virginia* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 *Single*, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Mrs. Ella E. Jones*6 DATE OF BIRTH (month, day, and year) *unknown*7 AGE *38* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

William J. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Sarah Quinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Hospital Records

15

Filed

APR 9 1920

ROBERT E. KRAUTER Registrar

Serial Permit 01011

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 18th* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from *April 13th* 19*20*, to *April 15th* 19*20*, that I last saw him alive on *April 18th* 19*20*, and that death occurred, on the date stated above, at *7 P* m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus(duration) *3* yrs. \pm mos. \pm ds.

CONTRIBUTORY (Secondary)

Diabetic Coma(duration) yrs. mos. *3* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *H. G. Doughty* V. R. Macom, M. D., 19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Ex more**April 9 1920*

20 UNDERTAKER

W. J. Schmeiss

ADDRESS

Walt Ave

TION is very important. See instructions on back of certificates.

D42332

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D42332
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2737 *Rayner - Av.* ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Anna S. Jacob

(a) RESIDENCE. NO.

2737 *Rayner Av.* ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

George E. Jacob

6 DATE OF BIRTH (month, day, and year)

June 1899

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

20

10

—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Samuel Stocks

11 BIRTHPLACE OF FATHER (city or town) (State or country)

York Pa.

12 MAIDEN NAME OF MOTHER

Mary Shaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md. Maryland

14 Informant (Address)

George E. Jacob 2737 Rayner Av.

15

APR 9 1920

ROBERT F. EBAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 17 1920*

17

I HEREBY CERTIFY, That I attended deceased from April 16th, 1920, to April 16th, 1920, that I last saw her alive on April 16th, 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*Baltimore*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *E. d. w.*

(Signed)

Walter E. Samples, M. D.

, 19 (Address)

1013 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Western Cemetery**April 19 1920*

20 UNDERTAKER

ADDRESS

*Geo. Leimbach & Son**627 N. 2nd St.*

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42333

CERTIFICATE OF DEATH.

79 D42333
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3208 Oakfield Ave. ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Laura McKnew Ward

(Residence in Baltimore: No. 3202 Oakfield Ave St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female.

4-COLOR OR RACE,

White

5-~~SINGLE~~
MARRIED, *Married*
WIDOWED,
OR DIVORCED,
(Write the word)

6-DATE OF BIRTH,

Nov 17, 1896
(Month) (Day) (Year)

7-AGE,

43 yrs. 5 mos. ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

Howard Co. Md.

PARENTS.

10-NAME OF FATHER,

Joseph McKnew

11-BIRTHPLACE OF FATHER
(State or Country),

Proctor Springs Md.

12-MAIDEN NAME OF MOTHER

Laura Mercer

13-BIRTHPLACE OF MOTHER
(State or Country),

Howard Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Granville Hard*(Address) *3202 Oakfield Ave*

15-

APR 19 1920

Filed..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 16, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 15 1920, to April 16 1920

that I saw her alive on April 16 1920,

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Smelly - Arterio Sclerosis
Endocarditis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY

(Secondary) *Arterio Sclerosis, Endocarditis*

(Duration).....yrs.....mos.....ds.

(Signed) *W. H. Felt*

M. D.

J. B. T., 1920 (Address) *106 S. Green St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Landon Park Cemetery

DATE OF BURIAL,

Apr. 19, 1920

20-UNDERTAKER

Geoff Smith

ADDRESS

10008
Fayette St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42334

CERTIFICATE OF DEATH.

55
D42334
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 N. Monument ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 212 N. Monument St. St.; 69 yrs., 9 mos., 25 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

F

4-COLOR OR RACE

W

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Widow

6-DATE OF BIRTH.

June 22, 1850
(Month) (Day) (Year)

7-AGE,

69 yrs., 9 mos., 25 da.If LESS than 1 day,
...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE,
(State or Country),

Maryland

PARENTS.

10-NAME OF FATHER,

Dr. J. J. Lockrell

11-BIRTHPLACE OF FATHER
(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Mary E

13-BIRTHPLACE OF MOTHER
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Walter E. Carroll

(Address)

1325 Brick Bldg - Pittsburg Pa

15-

Filed

APR 9 1920

ROBERT A. LAUTER

BRIAL FIRM

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr 17, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from March 15 1912, to April 16 1912, that I saw her alive on April 16 1912, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica
(Paraphernal type)
(Duration).....yrs...1...mos.....da.CONTRIBUTORY
(Secondary)(Signed).....John O. Mitchell.....M. D.
Apr 18, 1920 (Address).....1025 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Green MountApril 19 1920

20-UNDERTAKER

ADDRESS

John O. Mitchell 1301 W. Fayette

D42335

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42335

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? 16 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lorette F. Bange

6 DATE OF BIRTH (month, day, and year) Apr 1 1865

7 AGE Years 55 Months 15 Days 15 LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Train Director

(b) General nature of industry, business, or establishment in which employed (or employer) Penna R.R.

(c) Name of employer Hanover Pa

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Fred. L. Bange

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Straub

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant (Address) Lorette F. Bange Elderslie Ave 710 Washington

15 APR 9 1920 ROBERT A. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1920

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1920, to April 16, 1920, that I last saw him alive on April 16, 1920, and that death occurred, on the date stated above, at 10 30 P. m. The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? see remarks (Signed) John D. Bubert M. D.

16, 1920 Address 4854 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Woodlaw Cemetery Apr. 20 1920

20 UNDERTAKER John O. Mitchell 261 N. T. Ave

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42336

CERTIFICATE OF DEATH.

79

D42336

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *728 W. Mulberry* ST.: *18* WARD)2-FULL NAME *Louisa Meinerke*(Residence in Baltimore: No. *728 W. Mulberry* St.: *50* yrs., *4* mos., *10* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Wid*6-DATE OF BIRTH, *June 10*, *1832*

(Month)

(Day)

(Year)

7-AGE, *87* yrs., *10* mos., *15* ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Germany*

PARENTS.

10-NAME OF FATHER, *Fredrick Braudt*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert E. Braudt*(Address) *728 W. Mulberry St.*

15-

APR 19 1920

ROBERT E. BRAUDT

Borial Permitter

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Apr 16*, *1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Apr 11* 19*20*, to *Apr 16* 19*20*that I saw h... alive on *Apr 16* 19*20*and that death occurred, on the date stated above, at *4:30 P.*

The CAUSE OF DEATH* was as follows:

*Coronary Disease of Heart. Arterio-sclerosis.*CONTRIBUTORY (Secondary) *Palmyr Chestnut*(Signed) *J. H. Woodward*

M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park*DATE OF BURIAL, *Apr 19* 19*20*20-UNDERTAKER, *John C. Mitchell*ADDRESS, *1301 W. Fayette St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42337

CERTIFICATE OF DEATH.

91-079 D42337

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2845 N Calvert St. ST.; 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Sommers Field(a) RESIDENCE. NO. 2845 N Calvert St. ST.; 12 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofMarie Wood Field6 DATE OF BIRTH (month, day, and year) Jan 14 18647 AGE Years 55 Months 4 Days 3 If LESS than 1 day, hrs. — or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)10 NAME OF FATHER Samuel Field11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)12 MAIDEN NAME OF MOTHER Sarah V. Field13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)14 Informant James H. Preston
(Address) 820 N. Charles St.15 Filed APR 9 1920 Registrar W. H. Krauth

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 19 2017 I HEREBY CERTIFY, That I attended deceased from Feb 3rd, 19 20, to April 17th, 19 20.that I last saw him alive on April 17th, 19 20, and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia(duration) 2 yrs. 2 mos. 2 ds.

CONTRIBUTORY

(Secondary)

Endocarditis (duration) — yrs. — mos. — ds.18 Where was disease contracted Not known
If not at place of death?Did an operation precede death? No Date of —Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fredrick S. Owen M. D., 19 (Address) 7877 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Pratt Station Middlebury Va April 20 1920

20 UNDERTAKER

ADDRESS —Henry S. Jenkins So. 60 N. Calvert St.

THIS IS VERY IMPORTANT. See INSTRUCTIONS ON BACK OF CERTIFICATE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42338

D42338

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Josephs Hosp.* ST.: *9* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Isabella Graham*(a) RESIDENCE. No. *Richmond Va.* ST.: *Richmond Va.*

(Usual place of abode)

WARD.

(If nonresident give city and State)

Length of residence in city or town where death occurred

— yrs. *4* mos.

ds.

How long in U. S., If of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

W.

5 Single, Married, Widowed or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1888*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

32

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*L. I.*10 NAME OF FATHER *Richard Graham*

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*12 MAIDEN NAME OF MOTHER *Isabella Kegan*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

J. L. Graham Richmond Va

15

File

APR 19 1920 ROBERT E. KAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 18* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 5, 1920, to Apr. 18, 1920,*that I last saw him alive on *Apr. 18, 1920,*and that death occurred, on the date stated above, at *5 a. m.*

The CAUSE OF DEATH* was as follows:

Myocardial Infarction(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

Tuberculosis Rt. Hip(duration) yrs. *6* mos. ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Frank C. Marino*, M. D.*Sp. 18, 1920 Address: St. Joseph's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Richmond Va**4/20* 19 *20*

20 UNDERTAKER

ADDRESS *178**Robert Brookerson Calhoun*

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42340

CERTIFICATE OF DEATH.

93 D42340

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1145 Riverside* ST. *4th* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME *Leonard Leroy Thos Shilton*(Residence in Baltimore: No. *1145 Riverside* ST. *4th* yrs. *1* mos. *19* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *M*4-COLOR OR RACE, *white*5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *2* *27*, 19*13*.

(Month)

(Day)

(Year)

7-AGE, *7* yrs. *1* mos. *19* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country), *Balto City*10-NAME OF FATHER, *Harry Shilton*11-BIRTHPLACE OF FATHER
(State or Country), *Chisfield MO*12-MAIDEN NAME OF MOTHER *Mary Schaffer*13-BIRTHPLACE OF MOTHER
(State or Country), *Balto*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Shilton*(Address) *1145 Riverside*

15-

Filed *APR 19 1920*

Special Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *4* *16*, 19*20*.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *4. 13* 19*20*, to *4. 16* 19*20*, that I saw him alive on *4. 16* 19*20*, and that death occurred, on the date stated above, at *4. 16* p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia
.....
..... (Duration)..... yrs. *1* mos. ds.CONTRIBUTORY (Secondary) *Septic Infection*(Signed) *J. J. Murlington* M. D.
4. 16, 1920 (Address) *102 E. Fort St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *London Park*DATE OF BURIAL, *4-19, 1920*20-UNDERTAKER *E & B Harle*ADDRESS *115 E. West St.*

D42341

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42341

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 Columbia ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE, NO. 924 Columbia ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle Mansdorf6 DATE OF BIRTH (month, day, and year) 10-24-18857 AGE Years 34 Months 5 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Barlett & Hayward9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Fredrick Mansdorf11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)12 MAIDEN NAME OF MOTHER Mary E. Raw13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)14 Informant Mary Mansdorf (Mother) (Address) 924 Columbia15 Filed APR 9 1920 ROBERT E. BAUTER Registrar

Serial Permit Stamp

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-16 192017 I HEREBY CERTIFY, That I attended deceased from April 1, 1920, to April 16, 1920, that I last saw her alive on April 16, 1920, and that death occurred, on the date stated above, at 11 P m. The CAUSE OF DEATH* was as follows:Acute Intestinal NephritisCONTRIBUTORY (Secondary) Exposure & Grip (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen A. Dean M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cem4-20 1920

20 UNDERTAKER

ADDRESS

James Dignaut & Son 1000 S. Paca St

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42342

CERTIFICATE OF DEATH.

103 D42342

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 N. Eden ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Helen Johnson

(a) RESIDENCE. No.

706 N. Eden

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem	4 COLOR OR RACE Black	5 Single, Married, Widowed, or Divorced (write the word) Widow
5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daughter of Jim Johnson		
6 DATE OF BIRTH (month, day, and year) 1869		
7 AGE about 51	Years Months Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Jim Keene

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Harriet Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

John R. Keene
706 N. Eden

15

Filed

APR 9 1920

ROBERT B. KAUTER

Registrar

Burial Permit 0107

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-16 1920

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1920, to April 16, 1920, that I last saw her alive on " " " " 1920

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. 7 ds.

CONTRIBUTORY Chronic Catarrh, Gastritis (Secondary) (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Warner, M. D.

19 (Address) 308 B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Zion

4/19 1920

20 UNDERTAKER

ADDRESS

William Cook

507 E. North

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42343

CERTIFICATE OF DEATH.

179
REGISTERED NO. C

D42343

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St. 54 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Married

6-DATE OF BIRTH,

June 19, 1838.
(Month) (Day) (Year)

7-AGE,

8 1/2 yrs. 10 mos. ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Stone Cutter
675

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OR FATHER,

Matthias Kloetsch

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Mary Meyers

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

APR 9 1920

ROBERT B. KLAUTER

Official Public Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 18, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 10th 1920, to April 18th 1920,
that I saw him alive on April 11th 1920,
and that death occurred, on the date stated above, at 8-10 AM.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.
(Signed) H. S. Hammer, M. D.
April 8, 1920. (Address) 1929 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 1/2 yrs. mos. ds. In the 54 yrs. mos. ds. State

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

Holy Redeemer 4/20, 1920

20-UNDERTAKER

ADDRESS

Wm. Coyle 5076 North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42344

D42344

CERTIFICATE OF DEATH.

28
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tubercular Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Felix Schminisky(a) RESIDENCE. NO. 521 S. Linwood Ave. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 1 mo. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Schminisky6 DATE OF BIRTH (month, day, and year) May 30 18697 AGE Years 50 Months 10 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland (State or country)10 NAME OF FATHER Albert Schminisky11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)12 MAIDEN NAME OF MOTHER Ruby Mazan13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14

Informant Municipal Tubercular Hospital (Address)

15

File APR 9 1920 ROBERT H. LAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18 19 20

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 23, 19 20, to Apr. 17, 19 20,that I last saw him alive on April 17, 19 20,and that death occurred, on the date stated above, at 5:45 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) 13 yrs. 1 mos. 1 ds.CONTRIBUTORY P. Tubercular Laryngitis (Secondary)(duration) 7 yrs. 7 mos. 1 ds.

18 Where was disease contracted? if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) George H. Wilkins, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Healy Redeemer4/20 19 20

20 UNDERTAKER

ADDRESS

Wm. Cook507 E. North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42345

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2315 Ruskin Ave. ST. 13 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2315 Ruskin Ave. St. 35 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH. Do not know 1 (Month) (Day) (Year)

7-AGE. (as above) 70 yrs. mos. ds. If LESS than 1 day,hrs. or....min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country) Mich. Conn.

10-NAME OF FATHER. Do not know

11-BIRTHPLACE OF FATHER. (State or Country) Do not know

12-MAIDEN NAME OF MOTHER. Do not know

13-BIRTHPLACE OF MOTHER. (State or Country) Do not know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Parker (Address) 2315 Ruskin Ave.

15-APR 19 1920

Filed. 191. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. April 17, 1920 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from March 29, 1920, to April 17, 1920, that I saw him alive on April 15, 1920, and that death occurred, on the date stated above, at 4-45 am. The CAUSE OF DEATH* was as follows:

Arterio-sclerosis.

(Duration) 2 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Disease.

(Signed) J. B. H. (Address) 1429 W. 4th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. Northboro Mass.

20-UNDERTAKER. Harry W. Ehlen

DATE OF BURIAL.

Apr. 21, 1920

ADDRESS 1429 W. 4th St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42346

CERTIFICATE OF DEATH.

37

D42346

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1131 McElderry*)ST. *5* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Leueinis Pinkett(a) RESIDENCE. NO. *1131 McElderry*

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

colored

5 Single, Married, Widowed, or Divorced (write the word)

*married*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Clay Pinkett*

6 DATE OF BIRTH (month, day, and year)

Jan 14/1885

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

min.

*35**10**3**3*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Lexington N.Y.*

10 NAME OF FATHER

Howard Covington

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Lexington N.Y.

12 MAIDEN NAME OF MOTHER

Lulin Carter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Lexington N.Y.

PARENTS

14 Informant

(Address)

Clay Pinkett
1131 McElderry St

15

APR 19 1920

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 17 1920*

17

I HEREBY CERTIFY, That I attended deceased from
April 10 1920 to *April 17 1920*,
that I last saw him alive on *April 17 1920*.and that death occurred, on the date stated above, at *4 P.* m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism(duration) yrs. mos. *7* ds.CONTRIBUTORY
(Secondary)(duration) *1* yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

Robert J. Green M. D.4-18-1920 (Address) *120 1/2 1st St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Paul's Church**April 20 1920*

20 UNDERTAKER

ADDRESS

R. B. Cross 1405 McElderry St

D42347

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1050 Raborg* ST. *18* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1050 Raborg*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and put out No. 18.)

Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>male</i>	4-COLOR OR RACE, <i>Colored</i>	5-SINGLE, <i>Single</i> MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
6-DATE OF BIRTH, <i>Jan 11, 1918</i> (Month) (Day) (Year)		
7-AGE, <i>7</i> yrs. <i>3</i> mos. <i>6</i> ds. If LESS than 1 day,hrs. or....min.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>none</i> (b) General nature of industry, business, or establishment in which employed (or employer).....		
9-BIRTHPLACE, (State or Country), <i>Ind</i>		
PARENTS.	10-NAME OF FATHER, <i>Shos Brown</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Ind</i>	
	12-MAIDEN NAME OF MOTHER <i>Monika Collins</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Ind</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Monika Brown*(Address) *1050 Raborg*

15-

APR 19 1920

Filed

191

ROBERT R. KRAUTER

BRIEF FORM Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Apr 17, 1920*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest*, au-topsy or inquiry, and that said deceased came to *the* death on the day stated above.

The CAUSE OF DEATH* was as follows:

No. 18 Freedom

(Duration)yrs.mos.ds.

CONTRIBUTORY
(Secondary)

(Duration)yrs.mos.ds.

(Signed) *J. Edgar Smith*

(Coroner)

4/18/20 (Address) *910 Sept St*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of deathyrs.mos.ds. Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

D42349

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42349

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital, Bay View 5 WARD)

2-FULL NAME

William Cole(a) RESIDENCE. NO. 79 N. Spring

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year)

7 AGE

47

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Montgomery Co. Md.

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address)

Hospital Records City Hospital Bay View
ROBERT K. LAMOTHE
Registrar

15

APR 9 1920

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18, 192017 I HEREBY CERTIFY, That I attended deceased from March 24, 1920, to April 18, 1920, that I last saw him alive on April 18, 1920, and that death occurred, on the date stated above, at 8:35 A.M.

The CAUSE OF DEATH was as follows:

Carcinoma of stomach

CONTRIBUTORY (Secondary)

(duration) One yrs. mos. ds. Secondary Anemia

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? X-rays(Signed) W. H. Henderson, M. D.

, 19

(Address)

City Hospital

*State the Disease Causing Death or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laurel

DATE OF BURIAL

April 20
Address 1502

20 UNDERTAKER

John W. Henderson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42350

CERTIFICATE OF DEATH.

D42350

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Lathrop St. ST.: 17 WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sammy Waters

(a) RESIDENCE. No. 1608 Lathrop St. ST. _____ WARD. _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Waters

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE 73 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) Farming

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

10 NAME OF FATHER Chas. Waters

11 BIRTHPLACE OF FATHER (city or town) Ind
(State or country)

12 MAIDEN NAME OF MOTHER Harriet

13 BIRTHPLACE OF MOTHER (city or town) Ind
(State or country)

14 Informant Nellie Waters
(Address) 1608 Lathrop St.

15 APR 19 1920 ROBERT H. TRAUTER Registrar
Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1920

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1920, to April 15, 1920, that I last saw him alive on April 15, 1920, and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:
Acute pneumonia hepatic
over

(duration) ? yrs. ? mos. 5 ds.

CONTRIBUTORY Acc. and Trauma
(Secondary)

(duration) ? yrs. ? mos. 6 ds.

18 Where was disease contracted if not at place of death? mountain

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? urinary

(Signed) Ed S. Hall M. D.

19 (Address) 426 E 23 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Auburn 4-19 1920

20 UNDERTAKER ADDRESS 142

John H. Trautman Wheat

UTION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42351

CERTIFICATE OF DEATH.

82

D42351

1-PLACE OF DEATH

M. J. Johnson & Washington Place

REGISTERED NO.

CITY OF BALTIMORE: (No. *Washington Apt* ST.: *11* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Virginia Johnson Pegram Mc-Intosh

(a) RESIDENCE. No.

Washington Apt

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *50* yrs.

mos.

ds.

How long in U. S., if of foreign birth? *Life* yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Late David G. Mc-Intosh

6 DATE OF BIRTH (month, day, and year)

July 15 1878

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*76**9**3*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Richmond Virginia

10 NAME OF FATHER

J. D. Pegram

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Richmond Virginia

12 MAIDEN NAME OF MOTHER

Virginia Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Richmond Virginia

14

Informant (Address)

Dr. G. H. Mc-Intosh 216 N. E. St.

15

APR 19 1920

ROBERT A. KLAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 18 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*April 11th, 1920, to April 18th, 1920,*that I last saw her alive on *April 18th, 1920,*and that death occurred, on the date stated above, at *12:30 A.M.*

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis (arterio-sclerosis)(duration) yrs. mos. *7* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *4* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical only*(Signed) *H. C. Leonard M.D.*19 (Address) *8 E. Eager St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Richmond Virginia**April 20 1920*

20 UNDERTAKER

ADDRESS

Henry J. Perkins, Sons Co. Mc-Intosh

TION is very important. See instructions on back of certificate.

D42352

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42352

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1235 Division

ST.:

WARD)

2-FULL NAME

Lucinda Buckner

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE

No. 1235 Division

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female Colored Widowed

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar 12-1872

7 AGE

48 Years

1 Months

4 Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md

10 NAME OF FATHER

Wm Boyer

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Matilda Doran

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Md

14

Informant
(Address)Mrs Taylor
1235 Division St

15

APR 19 1920

ROBERT E. KAUFER
Registrar

Serial Permit 0100

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 16 1920

17

I HEREBY CERTIFY, That I attended deceased from

12-1-1919, to 4-16-1920.

that I last saw him alive on 4-16-1920.

and that death occurred, on the date stated above, at 6:55 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. G. M. D.

4-17-1920 (Address) 430 - W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn City Apr 18 1920

20 UNDERTAKER

ADDRESS

George H. Holland 1631 Union
Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42353

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 537 Mosher ST.: 14 WARD)

2-FULL NAME

(a) RESIDENCE. No. 537 Mosher ST.: 14 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male Colored Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Agulla Dickerson

6 DATE OF BIRTH (month, day, and year)

Mar 15/1865

7 AGE

Years

Months

Days

If LESS than

1 day.....hrs. or.....min.

55

1

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

Grocery Dep't

(c) Name of employer

C & P. S. Co.

9 BIRTHPLACE (city or town) (State or country)

Va.

10 NAME OF FATHER

?

11 BIRTHPLACE OF FATHER (city or town) (State or country)

?

12 MAIDEN NAME OF MOTHER

Emily Dickerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

14

Informant (Address)

Agulla Dickerson 537 Mosher St

15

APR 19 1920

ROBERT H. LAUTER Registrar

Baptist Permit 0107

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Mar 9, 1920, to Apr. 16, 1920.

that I last saw him alive on Apr 15, 1920.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed)

E. William Frey M. D.

4/17, 1920 (Address)

1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Auburn

APR 18 1920

20 UNDERTAKER

JAMES H. DENNIS

ADDRESS

1303 PRESTMAN ST. D.

TIONS are very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42354

D42354

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2705 Roslyn Ave. 16 WARD

2-FULL NAME: *Frederick Cyrus Ellis*(a) RESIDENCE. No. 2705 Roslyn Ave. ST.,
(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret S. Ellis

6 DATE OF BIRTH (month, day, and year) Aug 11, 1849

7 AGE Years 70 Months 8 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Catawissa (State or country) Penna

10 NAME OF FATHER Clinton Ellis

11 BIRTHPLACE OF FATHER (city or town) Catawissa (State or country) Penna

12 MAIDEN NAME OF MOTHER Carolyn Brobst

13 BIRTHPLACE OF MOTHER (city or town) Catawissa (State or country) Penna

14 Informant Frank A. Ellis (Address) 2705 Roslyn Ave.

15 Filed APR 19 1920 ROBERT B. KLAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1920, to April 16, 1920, that I last saw him alive on April 16, 1920, and that death occurred, on the date stated above, at 5:15 P. M. The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY Causes: Sclerosis & nephritis (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical - B.P. analysis

(Signed) Ch. F. Schenck M. D.

(Address) 2806 Sarason Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Va 16 Apr 1920

20 UNDERTAKER J. F. Schenck & Sons ADDRESS North Ave.

Burial Permit 0147

CAUTION: This is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42355

CERTIFICATE OF DEATH

079
91- D42355

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

Washington Road

ST.: 70 WARD)

2-FULL NAME

Joseph Le Hoyer

(a) RESIDENCE. NO.

Washington Road

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

40 yrs. 6 mos. 14 ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 31 - 1889

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

40

6

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Crown Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

Safe Builder

(c) Name of employer

Miller Safe Co

9 BIRTHPLACE (city or town)
(State or country)Baltimore
Md.

10 NAME OF FATHER

Joseph H Hoyer

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Ella Watterman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Md.

14

Informant
(Address)Lester Hoyer
Washington Road

15

Filed

APR 19 1920

Serial

Faint

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4 17

1920

17

I HEREBY CERTIFY, That I attended deceased from

April 11, 1920, to April 17, 1920.

that I last saw him alive on April 17, 1920.

and that death occurred, on the date stated above, at 5:15 P. M.

The CAUSE OF DEATH* was as follows:

Coronary Insufficiency

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Thos. Hall

M. D.

19 (Address)

Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Landon Park

DATE OF BURIAL

April 20 1920

20 UNDERTAKER

H. J. Dickner

ADDRESS

North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4006* ST. *15* WARD)2-FULL NAME *Heber Smith*(a) RESIDENCE. No. *4006* ST. *15* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *33* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mary V. Smith*6 DATE OF BIRTH (month, day, and year) *1865*

7 AGE

Years *55*

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Druggist*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md*10 NAME OF FATHER *Benz Smith*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md*12 MAIDEN NAME OF MOTHER *Ely. Hayward*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *West India*

14

Informant (Address) *Mary Smith*

15

APR 19 1920

ROBERT A. KAUTER
Registrar
Baird Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 17* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from *April 11*, 19*20*, to *April 16*, 19*20*.that I last saw him alive on *April 16*, 19*20*.and that death occurred, on the date stated above, at *9 a* m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
about (duration) *2* yrs. mos. ds.CONTRIBUTORY (Secondary) *Bronchitis*(duration) yrs. mos. ds. *2* ds.18 Where was disease contracted if not at place of death? *at work*Did an operation precede death? *no* Date of *ap*Was there an autopsy? *no*What test confirmed diagnosis? *Urinary Exams*(Signed) *Wm D Wells*, M. D., 19 (Address) *Arundel*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Green Ridge Cem*DATE OF BURIAL *April 19* 19*20*20 UNDERTAKER *Wm D Wells*ADDRESS *Arundel*

CAUSE OF DEATH IS VERY IMPORTANT. See instructions on back of certificates.

D42357

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

Shordon 42

D42357

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

3021 E. Baltimore

ST.

WARD)

2-FULL NAME

Josephine Katherine Shordon

(Residence in Baltimore: No.

3021 E. Baltimore St.

St.: 9

yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

widow

6-DATE OF BIRTH

May

24, 1847

7-AGE

72

yrs.

10

mos.

25

ds.

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9-BIRTHPLACE

(State or country)

New York City

10-NAME OF FATHER

Mary Lyons,

11-BIRTHPLACE OF FATHER
(State or country)

New York City

12-MAIDEN NAME OF MOTHER

Joseph

13-BIRTHPLACE OF MOTHER
(State or country)

Cuba

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Allevell

(Address)

3021 E. Baltimore St.

15-

Filed

APR 19 1920

ROBERT H. KAUTER

Marital Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

April

18

1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from

March 20, 1912, to April 18, 1920

that I saw her alive on April 17, 1920

and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed), Allen E. Beutham M. D.

4-15-20, 1920 (Address) 3139 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Lawn Cemetery

4/19, 1920

20-UNDERTAKER

J. J. Moran

ADDRESS

3000 E. Baltimore St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42358

151 D42358

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2631 Madison St.;

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Howard

(Residence in Baltimore: No. 2631 Madison St.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

April 19, 1920
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day,
1...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Matthew Howard

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Joseph Rynes

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Matthew Howard

(Address)

2631 Madison St.

15-

ROBERT E. KRAUTH

Filed

APR 19 1920

Baltimore City Health Department Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 19, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

April 19, 1920, to April 19, 1920,

that I saw him alive on April 19, 1920,

and that death occurred, on the date stated above, at 5:45 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

April 19, 1920 (Address) 801 N. Keeweenaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Mother

DATE OF BURIAL,

April 19, 1920

20-UNDERTAKER

Gaut & Co. Son

ADDRESS

1406 Calhoun

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42359

CERTIFICATE OF DEATH.

151 D42359

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, 1...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

APR 19 1920

ROBERT H. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

April 19 1920, to April 19 1920,

that I saw her alive on April 19 1920,

and that death occurred, on the date stated above, at 5 A.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs.....mos.....ds.

(Signed) W. J. P. Jones

April 19, 1920 (Address) 801 N. Kenwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer

April 19, 1920

20-UNDERTAKER

ADDRESS

E. J. Jones

1000 N. E. St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42360

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *22* WARD)2-FULL NAME *Rose Orlandi*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. *826 Burgundy*
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *5* yrs. mos. ds. How long in U. S., if of foreign birth? *5* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced
HUSBAND of *Tony Orlandi*
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Under*7 AGE Years *24* Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Italy*
(State or country)10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) *Italy*
(State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Italy*
(State or country)14 Informant *University Hospital Records*
(Address)15 Filed *APR 19 1920* *ROBERT E. KRAUTH* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 18, 1920*17 I HEREBY CERTIFY, That I attended deceased from *April 6, 1920*, to *April 18, 1920*, that I last saw her alive on *April 18, 1920*, and that death occurred, on the date stated above, at *7.30 P. m.*

The CAUSE OF DEATH* was as follows:

Abdominal Pregnancy(duration) yrs. *8* mos. ds.CONTRIBUTORY *Operative shock and*
(Secondary) *hemorrhage* (duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *Yes* Date of *April 18, 1920*Was there an autopsy? *No*What test confirmed diagnosis? *Operative findings*
(Signed) *J. A. Buchness*, M. D.19 (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

University Hospital
UNDERTAKER*4/19/20*
ADDRESS *1011 N. High*

TION is very important. See instructions on back of each of these forms.

The Mayor of the City of Valguarnera, Italy, writes that from the certificate of death must appear that is dead Russo Rosa and not Rosa Orlandi.

Russo Rosa is the maiden name while Orlandi is the husband's surname.

Therefore it is necessary to put in the certificate of the death, as name of the deceased: RUSSO ROSA wife of Ignazio Orlandi, and to inform the Health department accordingly.

UNIVERSITY HOSPITAL

LOMBARD AND GREENE STREETS

BALTIMORE, MD.

Dec. 1, 1920.

To the Health Dept.
Baltimore

The bearer is having
difficulty in a case of proof
of death of Rose Orlandi.
Since the people are prejudiced
it is difficult to get the
exact information but I
believe that Rose Orlandi
is Russo Rosa wife of
Ignazio Orlandi and if
there is any way to straighten
out this matter you
will oblige

John A. Buchness M.D.

Subscribed and sworn to before me this 1st day of
December 1920.

Eleanor L. Nichol
Notary Public.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42361

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Filed.

191.

ROBERT B. KRAUTH

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Coronary of Stomach.

(Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Signed) M.D.

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

JOHN F. DENNY

715 LIGHT ST.

important. See instructions on back of certificate.

D42362

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. Pier #5. Locust Point.

ST. 24

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Patrick Gaynor.

(Residence in Baltimore: No.

114-E. 101 St. New York.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-SINGLE, Married, Widowed, or Divorced, (Write the word.) Single.

6-DATE OF BIRTH, Do not know. 1 (Month) (Day) (Year)

7-AGE, 22 yrs. 7 mos. 7 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Deck Apprentice. (b) General nature of industry, business, or establishment in which employed (or employer), U.S. Training Ship, Alabat.

9-BIRTHPLACE, (State or Country), Ireland.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Metz. (Paymaster).

(Address) U.S. Training Ship, Alabat.

15-

APR 19 1920

ROBERT A. BRAUTER

Filed

101

Burial Place

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH, April 15th, 1920, 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said. (Inquest, au-

inquiry and that said deceased came to his death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

Apr. 18th 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence New York City.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, New York City APR 19 1920

20-UNDERTAKER, ADDRESS, JOHN F. DENNY 715 LIGHT ST.

D42363

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male
4-COLOR OR RACE, Colored
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, (Month) (Day) (Year)

7-AGE, 27 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Erector at
(b) General nature of industry, business, or establishment in which employed (or employer), Bethlehem Ship Building Corporation

9-BIRTHPLACE, (State or Country), Maryland

10-NAME OF FATHER, J. Henry

11-BIRTHPLACE OF FATHER, (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, E. Nichols

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar Nichols

(Address) 1949 Mulberry St.

15-APR 9 1920

Filed, 191

REGISTERED & TESTED
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 16, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Falling from a ladder. (Accidental)

CONTRIBUTORY (Secondary) Rupture of liver & stomach

(Signed) J. C. Smith, M. D.
(Coroner)

419, 1920 (Address) 715 Light St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cambridge Md

DATE OF BURIAL, April 19 1920

20-UNDERTAKER, John F. Denny

ADDRESS, 715 Light St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42361

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *107 S. Calhoun St.* ST.; *19* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *James H. S. Mitchell*(Residence in Baltimore: No. *107 S. Calhoun St.* St.; *38* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

April

(Month)

23

(Day)

1891

(Year)

7-AGE,

38

yrs.

11

mos.

23

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Plumber

(b) General nature of industry, business, or establishment in which employed (or employer).

George Bomgardt

9-BIRTHPLACE,

(State or Country)

Baltimore, Md.

PARENTS.

10-NAME OF FATHER,

B. L. Mitchell

11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore, Md.

12-MAIDEN NAME OF MOTHER

Annie E. Mann

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant):

Mrs. George Crofoot

(Address):

107 S. Calhoun St.

15-

APR 19 1920

ROBERT R. KAUFER

Filed.....

191.....

BUTAL 1812 Reg 101

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April

(Month)

15

(Day)

1920

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 25 1920, to *April 15 1920*,that I saw him alive on *April 14 1920*and that death occurred, on the date stated above, at *12:45 A.* m.

The CAUSE OF DEATH was as follows:

*Tuberculosis of Lungs**Asymptomatic of Lungs**(Duration).....yrs.....mos.....ds.*

CONTRIBUTORY (Secondary)

Simple (Duration).....yrs.....mos.....ds.(Signed) *Dr. W. W. Keenan**M. D.**April 16, 1920* (Address) *708 E. Madison St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Olivet Cemetery

DATE OF BURIAL,

April 18 1920

20-UNDERTAKER

Harry H. Nitzke

ADDRESS

1531 N. Carroll St.

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42365

CERTIFICATE OF DEATH.

1-PLACE OF DEATH USA General Hospital No.2

REGISTERED NO. C

CITY OF BALTIMORE: (No. Fort McHenry, Md.

ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles A. Grunert, Captain, Hq. Co. 82 Div.

(Residence ~~Fort McHenry~~ White Haven, Penna.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

30

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

USA Soldier in

(b) General nature of industry, business, or establishment in which employed (or employer).

US Army

9-BIRTHPLACE,

(State or Country),

Penna.

10-NAME OF FATHER,

David, Grunert,
White Haven, Penna.

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

APR 19 1920

Filed

191.

ROBERT E. BRAUTER

BALTIMORE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 18, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 30, 1919, to April 18, 1920,

that I saw him alive on April 18, 1920,

and that death occurred, on the date stated above, at 8:23 A.M.

The CAUSE OF DEATH* was as follows:

Sarcoma intra-abdominal, epigastric region, following orchidectomy (testicle) rt. performed July 4, 1918)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thomas J. Leary, Major, M.C.

Apr. 19, 1920, 191. (Address) Ft. McHenry, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

White Haven Pa

DATE OF BURIAL,

April 19, 1920

20-UNDERTAKER

Max Lunsen

ADDRESS 1127 E

Baltimore

important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated in years, months, and days. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

D42366

County _____

50 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. _____

D42366

Village or City Baltimore (No. 3051, Abell Ave. St. 12 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Josephine Hax

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH Feb 27, 1849
(Month) (Day) (Year)

7 AGE 71 yrs. 1 mos. 20 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Baltimore, Md

PARENTS
10 NAME OF FATHER Henry Michel
11 BIRTHPLACE OF FATHER (State or country) Germany
12 MAIDEN NAME OF MOTHER Bertha Whistler
13 BIRTHPLACE OF MOTHER (State or country) German

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Hax

(Address) 3051 Abell Ave.

15 APR 9 1920 ROBERT E. KRAUTER
Filed _____

Barial

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 17, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1920, to April 17, 1920
that I last saw her alive on April 17, 1920

and that death occurred on the date stated above, at 8:15 p.m.
The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Acute Dilatation of the
Secondary Heart (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Gustavus C. Colne, M. D.
Apr 19, 1920 (Address) 3014 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL 4/20, 1920

20 UNDERTAKER G. J. Fanning & Son ADDRESS 1938 E. Lafayette

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V.S. No. 1.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42367

CERTIFICATE OF DEATH

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

4-13-

1920

(Month)

(Day)

(Year)

7-AGE,

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Balto md

10-NAME OF FATHER,

Vincent Papa

11-BIRTHPLACE OF FATHER
(State or Country),

Italy

12-MAIDEN NAME OF MOTHER

Leonetta Baranov

13-BIRTHPLACE OF MOTHER
(State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Vincent Papa

(Address)

639 W. Saratoga

15-APR 19 1920

ROBERT A. KRAUTER

Filed..... 191...

BUREAU OF PUBLIC HEALTH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

4-18-

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

4-13-

1920,

to 4-18-

1920,

that I saw him alive on 4-18- 1920,

and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows:

general debility

(Duration)..... yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration)..... yrs. mos. ds.

(Signed)

Charles J. Festa

M. D.

210 Pearl st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Vincent Cemetery

4/19/20, 191...

20-UNDERTAKER

ADDRESS

John J. Lohman 1318 Light Street

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42368

CERTIFICATE OF DEATH.

REGISTERED NO. C

D42368

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *12 W. Hamburg* ST. *23* WARD)

2-FULL NAME

(Residence in Baltimore: No. *12 W. Hamburg* St.; *4* yrs., *1* mos., *1* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6-DATE OF BIRTH

Sept 10, 19*19*

(Month)

(Day)

(Year)

7-AGE

7 yrs., *8* mos., *8* ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Nurse

9-BIRTHPLACE, (State or Country),

Balto Md.

10-NAME OF FATHER,

Henry Prof.

11-BIRTHPLACE OF FATHER (State or Country),

Balto Md.

12-MAIDEN NAME OF MOTHER

Maggie Nelson

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Prof.*(Address) *12 W. Hamburg*

15-

Filed *APR 19 1920*

ROBERT B. REUTER

Baltimore Health Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

April 18th, 19*20*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from *April 18th 1920* to *April 18th 1920*, that I saw her alive on *April 18th 1920*, and that death occurred, on the date stated above, at *2 P.* m.

The CAUSE OF DEATH* was as follows:

Tonsillar Eplithesia(Duration) *—* yrs., *—* mos., *12* ds.

CONTRIBUTORY (Secondary)

(Duration) *—* yrs., *—* mos., *—* ds.(Signed) *Harry Heibel* M. D.*April 17th 1920* (Address) *1217 Danvers St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs., *—* mos., *—* ds. In the State *—* yrs., *—* mos., *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Grandon Park**4/19/20*

20-UNDERTAKER

ADDRESS

Chapman & Son *1139 Danvers*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42369

CERTIFICATE OF DEATH.

D42369

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, / hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

File

APR 9 1920

ROBERT E. KAUTER

Registrar

Burial Permit Class

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

4/18, 1920, to 4/18, 1920,

that I last saw her alive on 4/18, 1920,

and that death occurred, on the date stated above, at 1:45 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth well.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phy. Exam.

(Signed)

4/18, 1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Commissioner Health,

Per. Wm. E. WOODALL.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42370

CERTIFICATE OF DEATH.

D42370

1-PLACE OF DEATH

Boy River Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.;

WARD)

2-FULL NAME

Margaret Smallwood
809 N. Eden

(a) RESIDENCE. No.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Five

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Married.

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofGeorge Smallwood
1886

6 DATE OF BIRTH (month, day, and year)

1886

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

34

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Factory Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town)
(State or country)Baltimore
Md.

10 NAME OF FATHER

James Mulligan

11 BIRTHPLACE OF FATHER (city or town)

Baltimore
Md.

12 MAIDEN NAME OF MOTHER

Margaret Carter

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore
Md.

14

Informant
(Address)Boy River Hospital
Baltimore, Md.

15

Filed

APR 9 1920

ROBERT R. FLANNERY

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 17, 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 16, 1920, April 17, 1920,

that I last saw her alive on April 17, 1920,

and that death occurred, on the date stated above, at 5:50 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

Ac Delirium

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

Autopsy: Blood Culture

(Signed)

H. Fred Smith, M. D.

Address)

Boy River Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross Cemetery

April 21, 1920

20 UNDERTAKER

ADDRESS

Henry Horck

1301 E. Egan

TION is very important. See instructions on back of certificate.

D42371

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1440 Ward ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 1440 Ward ST. 21 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. Now long in U. S., if of foreign birth? 49 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Chisley6 DATE OF BIRTH (month, day, and year) 18707 AGE 49 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind.10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Richard Chisley (Address) 1440 Ward15 Filed APR 19 1920 ROBERT B. KAUTER Registrar

Serial Permit Closed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 192017 I HEREBY CERTIFY, That I attended deceased from April 1, 1920, to April 17, 1920, that I last saw her alive on April 14, 1920, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Intermittent Nephritis

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? W Date ofWas there an autopsy? W

What test confirmed diagnosis?

(Signed) Malcolm H. G. M. D.4/18/20 (Address) 729 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mulrum CemeteryApril 20 1920

20 UNDERTAKER

Malcolm H. G. Jones 241 Pine

CAUSE OF DEATH IN plain terms, so that it may be understood by the jury. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42372

CERTIFICATE OF DEATH.

64 D42372
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 Vinel St. ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1515 Vinel St. St.; 11 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow6-DATE OF BIRTH, Not known
(Month) (Day) (Year)7-AGE, 60 yrs., mos., ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Boarding house9-BIRTHPLACE, (State or Country), Lenox Co. Ga.10-NAME OF FATHER, John Erdner11-BIRTHPLACE OF FATHER (State or Country), Not known12-MAIDEN NAME OF MOTHER Not known13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Brown Ellis(Address) 1515 Vinel St.

APR 19 1920

ROBERT B. KRAUTH

Filed..... 101.....
MAY 1 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 16, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Apr. 15, 1920, to Apr. 16, 1920, that I saw her alive on Apr. 16, 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis
(Duration) yrs., mos., ds.CONTRIBUTORY (Secondary) (Signed) Chas. W. Carter M. D.
Apr. 19, 1920 (Address) 906 N. Mount St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.Where was disease contracted, if not at place of death? Former or usual residence 19-PLACE OF BURIAL OR REMOVAL, St. John's DATE OF BURIAL, Apr. 17, 192020-UNDERTAKER Brown & Tilden ADDRESS 114 N. School St.

D42373

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42373

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 345-8. 12th ST.; 26 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 345-8. 12th St.; 50 yrs., 0 mos., 0 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Widow

6-DATE OF BIRTH.

Nov. 16, 1886
(Month) (Day) (Year)

7-AGE,

33 yrs., 5 mos., 0 ds.

If LESS than 1 day,

....hrs. ormin.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

Retired

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Frank B. Harrison (son in law)

(Address).....

345-8. 12th St.

15-

APR 19 1920

Robert P. Harrison,

191.....

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 17, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 2 1920, to April 17 1920, that I saw her alive on April 16 1920, and that death occurred, on the date stated above, at 12.30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

Trauma (falling down stairs) (Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

4/18/20, 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Cem

DATE OF BURIAL,

April 20, 1920

20-UNDERTAKER

Lilly & Zeller

ADDRESS

408 S. Wolfe St

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42374

D42374

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1418 E. 14th St.)

WARD)

2-FULL NAME

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married*
(Write the word.)

6-DATE OF BIRTH,

....., 1868
(Month) (Day) (Year)

7-AGE,

52 yrs. 4 mos. 5 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country), *Cuba*10-NAME OF FATHER, *Juan Menocal*

11-BIRTHPLACE OF FATHER

(State or Country), *Cuba*

12-MAIDEN NAME OF MOTHER

Concepcion Castro

13-BIRTHPLACE OF MOTHER

(State or Country), *Cuba*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Robert P. Harrison,

Registrar.

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 18, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr. 15th 1920, to *April 18 1920*,that I saw her alive on *April 18 1920*,and that death occurred, on the date stated above, at *4:50 P.M.*

The CAUSE OF DEATH* was as follows:

Myocardial failure

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

Apr. 15, 1920 (Address) *1418 E. 14th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? *Cuba*Former or usual residence *Havana Cuba*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral *Apr. 20*, 1920

20-UNDERTAKER

ADDRESS

William F. Johnson *1827 W. North*

APR 19 1920

D42375

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91

D42375

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 Glenwood Ave ST.; 27 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Margaret M. Greevy

(Residence in Baltimore: No. 513 Glenwood Ave

St.; 55 yrs., 1 mos. — ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED, widowed,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

February 2, 1826
(Month) (Day) (Year)

7-AGE,

94 yrs. 2 mos. 2 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country).

Ireland

10-NAME OF FATHER,

Patrick M. Centre

11-BIRTHPLACE OF FATHER
(State or Country),

Ireland, County Mayo

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER
(State or Country),

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

APR 10 1920

Robert P. Harrison,

191.....

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 19, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 13 1920, to April 19 1920,

that I saw her alive on April 18 1920,

and that death occurred, on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration).....yrs.....mos. 2 ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos. 1 ds.

(Signed).....M. D.

April 19, 1920. (Address) 301. Shelden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 55 yrs. — mos. — ds. In the 69 yrs. — mos. — ds. State

Where was disease contracted, if not at place of death?

Place of Death

Former or usual residence

513 Glenwood Ave.

19-PLACE OF BURIAL OR REMOVAL,

St. Mary's & Son

DATE OF BURIAL,

Apr. 22, 1920

20-UNDERTAKER

Martin Fahy & Son 1827 N. North St.

D42376

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42376

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST.: *24* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Elik Gelba*(a) RESIDENCE. NO. *242 Pittsburg St.* ST.: *12th* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *unknown* yrs. mos. ds.How long in U. S., if of foreign birth? *10* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Widowed*6 DATE OF BIRTH (month, day, and year) *1887*

7 AGE

33

Years

Months

Days

If LESS than

1 day. hrs.

or min.

not known

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shipyard worker

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

9 BIRTHPLACE (city or town) *Russia*
(State or country)10 NAME OF FATHER *Joseph Sella*11 BIRTHPLACE OF FATHER (city or town) *Russia*
(State or country)12 MAIDEN NAME OF MOTHER *not known*13 BIRTHPLACE OF MOTHER (city or town) *Russia*
(State or country)

14

Informant
(Address)*Hospital Record*

PRI 1020

Robert T. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 19 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*April 18, 1920, to April 19, 1920,*that I last saw him alive on *April 18 at 11:30 PM, 1920,*and that death occurred, on the date stated above, at *1:55 A.M.*

The CAUSE OF DEATH* was as follows:

Fever (Unexplained)(duration) yrs. mos. *?* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? *?*
if not at place of death?Did an operation precede death? *?* Date ofWas there an autopsy? *No (not permitted)*

What test confirmed diagnosis?

(Signed) *J. G. Mateer*, M. D.*April 19 1920* (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Cem.**April 20 1920*

20 UNDERTAKER

ADDRESS

John Greblanchas 425 S. Pa

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42377

D42377

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

WARD.

Length of residence in city or town where death occurred 38 yrs.

mos.

ds. How long in U. S., if of foreign birth? 55 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or WIFE of)

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 16, 1920, to April 15, 1920,

that I last saw her alive on April 15, 1920,

and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
+ Mesenteric Thrombosis.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? yes Date of March 22-20

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Carl Chester Romine, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

TION is very important. See instructions on back of certificates.

APR 19 1920

Burial Permit Clerk

D42378

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42378

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

Jan 1850
(Month) (Day) (Year)

7-AGE,

70 yrs., 0 mos., 0 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Stationer
Book work9-BIRTHPLACE,
(State or Country)

Phila Pa

PARENTS.

10-NAME OF FATHER,

Wm M. Christy

11-BIRTHPLACE OF FATHER
(State or Country)

Phila Pa

12-MAIDEN NAME OF MOTHER

Mary Jane Maguire

13-BIRTHPLACE OF MOTHER
(State or Country)

Phila Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr 1911
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Nov 1896 1911, to Apr 1911

that I saw him alive on Apr 19 1911

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Cob (Duration) 0 yrs., 6 mos., 0 ds.

CONTRIBUTORY Chronic mania
(Secondary)

Cob (Duration) 4 yrs., 0 mos., 0 ds.

(Signed) Frank J. F. Lammery M. D.

1911 (Address) Mt Hope Retreat

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 24 yrs., 0 mos., 0 ds. In the State 24 yrs., 0 mos., 0 ds.

Where was disease contracted, Phila Pa
if not at place of death?

Former or usual residence Phila Pa

19-PLACE OF BURIAL OR REMOVAL,

Phila Pa

DATE OF BURIAL,

Apr 29 1911

20-UNDERTAKER
STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)ADDRESS
108 W. NORTH AVE.

APR 19 1920

D42379

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 D42379

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO

Belair Road and Kemmons Ave.
ST.: BOWARD)

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

2-FULL NAME

Francis W. Segrist

(a) RESIDENCE. NO.

Belair Rd. & Kemmons Ave.
ST.: BOWARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 4th 1919

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

7

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Overlea
Maryland

10 NAME OF FATHER

William Segrist

11 BIRTHPLACE OF FATHER (city or town)
(State or country)Baltimore
Maryland

12 MAIDEN NAME OF MOTHER

Barbara Becka

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Baltimore
Maryland

14

Informant
(Address)William Segrist
Rosedale, Ind.

15

Filed

19

Robert F. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 17 1920

17

I HEREBY CERTIFY, That I attended deceased from

4/16 1920, to 4/17 1920,

that I last saw him alive on 4/17 1920,

and that death occurred, on the date stated above, at 10:35 a.m.

The CAUSE OF DEATH* was as follows:

over

Broncho-Pneumonia

(duration) yrs. mos. 1 1/2 ds.

CONTRIBUTORY
(Secondary)

Mitral Regurgitation

(duration) yrs. 8 mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Sustan A. Fritz, M. D.

19 (Address)

Overlea

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Hill Cemetery

April 20 1920

20 UNDERTAKER

ADDRESS

Fred Lassman

Fullerton

TION is very important. See instructions on back of certificates.

D42380

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42380

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2nd. Seal Hospital* ST.: *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

21

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD. *Forest Hill Mch.*

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*W*5 Single, Married, Widowed,
or Divorced (write the word)*Married*

5a If married, widowed, or divorced

HUSBAND
(or) WIFE*Birth A. Rhodes*

6 DATE OF BIRTH (month, day, and year)

About 50 yrs ago

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*50*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Farmer*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

*Farmer*9 BIRTHPLACE (city or town,
State or country)*M.C.*

10 NAME OF FATHER

*Unknown*11 BIRTHPLACE OF FATHER (city or town,
State or country)*Unknown*

12 MAIDEN NAME OF MOTHER

*Unknown*13 BIRTHPLACE OF MOTHER (city or town,
State or country)*Unknown*

14

Informant
(Address)*James O. Rhodes*
Forest Hill

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 19 1920*

17

I HEREBY CERTIFY, That I attended deceased from

March 30, 19*20*, to *April 19*, 19*20*.that I last saw him alive on *4/9*, 19*20*.and that death occurred, on the date stated above, at *3:27* p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism
Removal by a wagon
accident of G. E. Smith Brown

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *Home*Did an operation precede death? *yes* Date of *4/15/20*Was there an autopsy? *yes*

What test confirmed diagnosis?

(Signed) *Chas. S. Fisher*, M. D., 19 (Address) *2nd Seal Hospital**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Bellair Mch.**Apr 20 20*

20 UNDERTAKER

ADDRESS

*Harry H. Witzke**1531 W. Lombard*

PRI 9 1920

D42381

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42381

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 347 Warren St. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John T. Corcoran

(a) RESIDENCE NO.

347 Warren St. 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 7 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 28-1898

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

20

7

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

General Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

Galvanizing Works

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

John T. Corcoran

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Catherine

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

14

Informant (Address)

J. Corcoran 347 Warren St.

Robert T. Harrison,

APR 9 1920

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1920

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1920, to April 16, 1920, that I last saw him alive on April 16, 1920, and that death occurred, on the date stated above, at 9:00 m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Phthisis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Harrison, M. D.

, 19 (Address) 835 Lytle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

April 20 1920

20 UNDERTAKER

ADDRESS

M. J. Flynn

1422 Light

D42382

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42382

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Filed

191

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to

on the day stated above.

The CAUSE OF DEATH was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address) 191

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

D42383

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42383

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 N. Linwood ST.; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles H Jewell

(a) RESIDENCE. NO.

205 N. Linwood ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs.

mos.

ds.

How long in U. S., if of foreign birth? Life yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Russ Jewell

6 DATE OF BIRTH (month, day, and year)

May 29—1856

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

671120

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Charles Jewell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Poffner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Edith Jewell
Hamilton, Md.Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 18 1920

17

I HEREBY CERTIFY, That I attended deceased from April 17, 1920, to April 19, 1920, that I last saw him alive on April 18, 1920, and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Sarcoma of neck
(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed)

, 19 (Address)

J. H. Robert M. D.
451 E. 22nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Green CemeteryApr 21 1920

20 UNDERTAKER

ADDRESS

J. L. Lellich2008 Orleans

TION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

D42381

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42381

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1766 E North Ave. St. 8

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria E Tankersley

(Residence in Baltimore: No. 1766 E North Ave. St. 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Married

6-DATE OF BIRTH,

July 16th, 1867
(Month) (Day) (Year)

7-AGE,

52 yrs. 9 mos. 1 ds.

If LESS than 1 day,
...hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).
None9-BIRTHPLACE,
(State or Country),

Md.

10-NAME OF FATHER,

Henry T. Gibson

11-BIRTHPLACE OF FATHER
(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Elizabeth Tankersley

13-BIRTHPLACE OF MOTHER
(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel J. Tankersley

(Address) 1766 E North Ave.

15-

APR 19 1920

Robert P. Harrison,

191

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 17th, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 17 1920, to April 17 1920, that I saw him alive on April 17 1920, and that death occurred, on the date stated above, at 7th m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

April 17, 1920 (Address) 1766 E North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Woodlawn Cemetery

DATE OF BURIAL,

April 20, 1920

20-UNDERTAKER

H. Ellen Fuller

ADDRESS

3517 Springdale Ave

D42385

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42385

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Md. General Hosp 12 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elizabeth Neukomne

(a) RESIDENCE. NO.

318 E. 28th ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

54 yrs. 11 mos. 2 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced

(or) WIFE of

Otto G. Neukomne

6 DATE OF BIRTH (month, day, and year)

May 15, 1865

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54

11

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto., Md

10 NAME OF FATHER

Albert Sturm

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Eliz. Linkel

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

William Garten 318 E. 28th St

15

Filed

APR 19 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-17 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 16th, 1920, to Apr. 17th, 1920.that I last saw her alive on Apr. 17th, 1920.

and that death occurred, on the date stated above, at 5:45 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos. 3 ds.

CONTRIBUTORY

Zotemia, Arteriosclerosis

(Secondary) Dilatation

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted

if not at place of death?

7.

Did an operation precede death?

Yes Date of Apr. 16th

Was there an autopsy?

No

What test confirmed diagnosis?

Operation

(Signed)

E. S. Coe

M. D.

4/7, 1920 (Address)

Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cem.

Apr 20 1920

20 UNDERTAKER

ADDRESS

Mr. Mrs. John W. Lufel

801 W. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42386

D42386

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1776 Pulaski St. 15 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. 1776 Pulaski St.

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH.

April 7, 1830
(Month) (Day) (Year)

7-AGE,

90

yrs., mos., ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Balto City

10-NAME OF FATHER,

Jacob Ritter

11-BIRTHPLACE OF FATHER, (State or Country),

Balto Co.

12-MAIDEN NAME OF MOTHER,

Margaret A. Bell

13-BIRTHPLACE OF MOTHER, (State or Country),

Balto Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Robert P. Harrison,

191

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 18, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 14 1919, to April 18 1920, that I saw her alive on April 17 1920, and that death occurred, on the date stated above, at 6 a. m. The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., ds.

(Signed)

April 19 1920 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

APR 19 1920

D42387

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42387

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 N Lombard ST.; 18 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1016 N Lombard St.; 11 yrs., — mos., — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)single

6-DATE OF BIRTH

Sept 28, 1871
(Month) (Day) (Year)

7-AGE,

49 yrs., 6 mos., 21 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... Engineer 030
(b) General nature of industry, business, or establishment in which employed (or employer)... American Coast Red Co.

9-BIRTHPLACE,

(State or Country), Maryland

10-NAME OF FATHER,

Terance Quigley

11-BIRTHPLACE OF FATHER

(State or Country), Ireland

12-MAIDEN NAME OF MOTHER

Annie Fendley

13-BIRTHPLACE OF MOTHER

(State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

APR 9 1920

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr 3 1920, to Apr 15 1920that I saw him alive on Apr 15, 1920;and that death occurred, on the date stated above, at 8:45 m.

The CAUSE OF DEATH* was as follows:

Asphyxia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) T. H. Harrison M. D.4/18, 1920 (Address) 1302 N Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Long Green Hayford Co. Md. April 21, 1920

20-UNDERTAKER

Harry H. Nitzke

DATE OF BURIAL,

ADDRESS

1531 N Lombard St

D42388

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 174

D42388

PLACE OF DEATH

CITY OF BALTIMORE (No.)

University Hospital

ST.: 4

WARD)

2-FULL NAME

Jessie M. Warrilow

(Residence in Baltimore: No.)

North East Md

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

May 12, 1912

7-AGE,

7 yrs., 11 mos., 6 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

hom

9-BIRTHPLACE, (State or Country),

Md

PARENTS.

10-NAME OF FATHER,

Joseph M. Warrilow

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Georgia Vandegrift

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Myrtle Vandegrift

(Address)

10. Balto. Hosp.

15-

Robert P. Harrison,

APR 9 1920

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 18, 1920

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

fractured skull

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Accident

(Duration) yrs. mos. ds.

(Signed) J. B. G. M. D.

4-19-1920 (Address) 117 N. Towson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence North East Md.

19-PLACE OF BURIAL OR REMOVAL,

North East Md.

DATE OF BURIAL,

April 20, 1920

20-UNDERTAKER,

H. H. Witzke

ADDRESS,

153 W. Lombard

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42389

D42389

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH *Church Home & Infirmary*CITY OF BALTIMORE: (No. *N. Broadway* ST.: *6th* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mr. Agnilla B. Whitaker*(Residence in Baltimore: No. *Forest Hill - Harford Co., Md* St.: *75* yrs., *2* mos., *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *he* 4-COLOR OR RACE, *W* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*6-DATE OF BIRTH. *Feb* *2* *1895*
(Month) (Day) (Year)7-AGE, *75* yrs., *2* mos., *2* ds. IF LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Farmer*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Forest Hill, Md.*10-NAME OF FATHER, *Joshua Whitaker*11-BIRTHPLACE OF FATHER (State or Country), *Forest Hill, Md.*12-MAIDEN NAME OF MOTHER *Elorella Price*13-BIRTHPLACE OF MOTHER (State or Country), *Annapolis Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *A. B. Whitaker*(Address), *Forest Hill, Md.*15-
Filed **APR 20 1920**

ROBERT E. KRAUTER

191... SPECIAL PERMIT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April* *19*, *1920*.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Feb 11* *1920*, to *April 19* *1920*, that I saw him alive on *April 19* *1920*, and that death occurred, on the date stated above, at *8 P. m.* The CAUSE OF DEATH* was as follows:*Diabetes Mellitus*(Duration) *3* yrs.mos.ds.CONTRIBUTORY (Secondary) *Erysipelas*(Signed) *Walter Anderson* M. D.*April 19*, *1920* (Address) *Church Home & Inf.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. *1* mos. *23* ds. In the *4* yrs. *2* mos. *2* ds. StateWhere was disease contracted, if not at place of death? *2*Former or usual residence *Forest Hill, Md.*19-PLACE OF BURIAL OR REMOVAL, *Rock Spring Md*DATE OF BURIAL, *April 21, 1920*20-UNDERTAKER *W. Dean Esau*ADDRESS *Rockair**Per J. B. Taylor 1404 Madison av*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42390

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE: No.

2-FULL NAME

(Residence in Baltimore: No.

ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Cul

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

Unknown, 1868 (Month) (Day) (Year)

7-AGE,

52 yrs., mos. ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Farmer

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

APR 20 1920

ROBERT E. KAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

April 18, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from that I saw him live on April 18, 1920, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* was as follows:

Hemiplegia

CONTRIBUTORY

(State the disease causing death, or, in deaths from violent causes, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

20-UNDERTAKER

DATE OF BURIAL,

ADDRESS

Mt Auburn

Joseph A. Farrell

April 23, 1920.

2319 Division St

D42391

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42391

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2411 Lovegrove Alley* ST. *12* WARD)REGISTERED NO. _____
(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)2-FULL NAME *Paul Anna Winters*(a) RESIDENCE. NO. *2411 Lovegrove Alley* WARD. _____
(Usual place of abode)(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. *70* mos. *3* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed,
or Divorced (write the word) *Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Sept. 15th 1919*7 AGE Years *7* Months *3* Days *3* If LESS than
1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work *None.*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md*
(State or country)10 NAME OF FATHER *Samuel Winters*11 BIRTHPLACE OF FATHER (city or town) *Baltimore*
(State or country)12 MAIDEN NAME OF MOTHER *Rosa Randall*13 BIRTHPLACE OF MOTHER (city or town) *Maryland*
(State or country)14 Informant *Rosa Winters*
(Address) *2411 Lovegrove Alley*15 *APR 20 1920* *ROBERT A. KRAUTH*
Registrar
Burial Permit *01003*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 20th 1920*17 I HEREBY CERTIFY, That I attended deceased from
April 17th 1920, to *April 20th 1920*,
that I last saw him alive on *April 20th 1920*,
and that death occurred, on the date stated above, at *12:45 a.m.*

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(duration) yrs. mos. *5* ds.CONTRIBUTORY *Exhaustion*
(Secondary)(duration) yrs. mos. *1* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Georgel E. Cross* M. D., 19 (Address) *100 W. 25th St**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*mt anbur**April 21 1920*

20 UNDERTAKER

ADDRESS

*Joseph A. Farrell**2319 Division*

D42392

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

153 D42392

PLACE OF DEATH

CITY OF BALTIMORE (No. *Harford av & north ave* 10th ST.)

WARD)

2-FULL NAME *Evelyn Kratz*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *708 Harford* —St.; yrs., mos. *14* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Bald.*
(Write the word.)6-DATE OF BIRTH, *Apr 3, 1920*

(Month)

(Day)

(Year)

7-AGE, *14* yrs., *14* mos., *14* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Bald.*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Balto*

PARENTS.

10-NAME OF FATHER, *John Kratz*11-BIRTHPLACE OF FATHER (State or Country), *Balto*12-MAIDEN NAME OF MOTHER, *Evelyn Mills*13-BIRTHPLACE OF MOTHER (State or Country), *Balto*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Kratz*(Address) *708 Harford*

15-

APR 20 1920

ROBERT B. KRAUTER

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Apr 17, 1920*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by

(Inquest, au-

topsy or inquiry.) find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Lack of care,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *John Kratz* M. D.4-20-20 (Address) *4-20-20*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Vincent center**April 20 1920*

20-UNDERTAKER

ADDRESS

Leo. Cork Harford & north ave.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42391

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Church Home and Infirmary

REGISTERED NO. C

CITY OF BALTIMORE: (No.

Brooklyn and Fairmount Ave

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mrs. Laura M. Dixon

(Residence in Baltimore: No.

Church Home and Infirmary

St.; — yrs., — mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Married

6-DATE OF BIRTH,

Jan 16, 1866

(Month)

(Day)

(Year)

7-AGE,

53

yrs.

10

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Harford Co. - Md.

10-NAME OF FATHER,

Martin Purcell

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Betty Harkness

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

L. A. Dixon

(Address)

Belair Md.

15-

Filed

APR 20 1920

ROBERT H. KAUTER

Baltimore Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 18, 1920

(Month)

(Day)

1920

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 17, 1920, to April 18, 1920,

that I saw her alive on April 18, 1920,

and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

Cardiac failure

(Duration).....yrs.....mos.....ds.

(Signed).....C. Lawrence C. Porter.....M. D.

April 20, 1920 (Address).....Church Home and Infirmary.....City?

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Belair Md.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Fryer Hill Md.

April 20, 1920

20-UNDERTAKER

ADDRESS

A. H. Harkness North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42395

CERTIFICATE OF DEATH.

170 D42395
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 Edgerale Rd ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Myland Coy

(Residence in Baltimore: No. 500 Edgerale Rd St. 49 yrs., 4 mos., 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male	4-COLOR OR RACE. White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married
6-DATE OF BIRTH. Dec. 5, 1876 (Month) (Day) (Year)		
7-AGE. 49 yrs., 4 mos., 13 ds. If LESS than 1 day, ...hrs. or...min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Ans. Ins. Com. I. G. 286		
9-BIRTHPLACE. (State or Country), Baltimore		

PARENTS.	10-NAME OF FATHER, James Myland Coy
	11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.
	12-MAIDEN NAME OF MOTHER Mary A. Shields
	13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Souize Coy

(Address) 500 Edgerale Rd.

 15- APR 20 1920
 Filed 191... Robert R. Krauter
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

 16-DATE OF DEATH,
 April 18, 1920
 (Month) (Day) (Year)

 17- I HEREBY CERTIFY, That I attended deceased from
 Feb. 15, 1920, to April 18, 1920,
 that I saw him alive on April 17, 1920,
 and that death occurred, on the date stated above, at 8:15 A. M.
 The CAUSE OF DEATH* was as follows:

 Chronic Nephritis
 (Duration) ... yrs. 8 mos. ... ds.

 CONTRIBUTORY... Trauma
 (Secondary)

 (Duration) ... yrs. 5 mos. 6 ds.
 (Signed) Lewis P. Haeberger, M. D.
 April 19, 1920 (Address) 1227 Eastern Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Greenwood, April 20, 1920

20-UNDERTAKER, ADDRESS

John O. Mitchell, 1201 W. ...

important. See instructions on back of certificate.

D42396

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42396

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *W.*
CITY OF BALTIMORE (No. *577 Hoffman* St. *17* WARD)
2-FULL NAME *Frank Curtis*
(Residence in Baltimore: No. *577 Hoffman* St.; *Life* mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX, *male* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)

6-DATE OF BIRTH, *November*, *1870*
(Month) (Day) (Year)

7-AGE, *50* yrs. *0* mos. *0* ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Labors*
(b) General nature of industry, business, or establishment in which employed (or employer), *040*

9-BIRTHPLACE, *Md (Baltimore)*
(State or Country),

10-NAME OF FATHER, *Geo. Curtis*

11-BIRTHPLACE OF FATHER, *Md.*
(State or Country),

12-MAIDEN NAME OF MOTHER, *Mosekalie*

13-BIRTHPLACE OF MOTHER, *Md.*
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Elizabeth Mink*
(Address) *577 Hoffman*

15-
Filed *APR 20 1920* *ROBERT I. KRAUTH*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH, *Apr.*, *18*, *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*, and that said deceased came to *his* death *on the day stated above.*
(top of inquiry.)

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Heart*
(Duration) yrs. mos. ds.

(Signed) *E. Smith* M. D.
(Coroner) *4/19/20* Address *910 E. 1st St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of deathf.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, *W. Clubman* DATE OF BURIAL, *Apr 21 1920*

20-UNDERTAKER, *Samuel Sunday* ADDRESS *378 N. Baltimore*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42397

CERTIFICATE OF DEATH.

170 D42397

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *704 Encore St* ST.; *11* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *925 Druid Hill Ave* St.; *18* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)

6-DATE OF BIRTH,

Unknown, 1880 (Month) (Day) (Year)

7-AGE,

40 yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Cook*
(b) General nature of industry, business, or establishment in which employed (or employer), *Private Family*

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Elizabeth Dorsey*(Address), *925 Druid Hill Ave*

15-

Filed

APR 20 1920

ROBERT H. KRAUTER

Baltimore Health Department

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April, 18, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 23 1920, to *April 8* 1920,that I saw her alive on *April 8* 1920,and that death occurred, on the date stated above, at *8:53 A. m.*

The CAUSE OF DEATH was as follows:

Apoplexy & Bright Disease(Duration), *3* yrs. *2* mos. *1* ds.

CONTRIBUTORY (Secondary)

(Duration), *3* yrs. *2* mos. *1* ds.(Signed), *Dr. J. M. Kennedy* M. D.*April 18, 1920* (Address), *208 E. Enoch St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Mt. Zion Cem**Apr 20, 1920*

20-UNDERTAKER

ADDRESS

Samuel J. Kennedy *3780 Biddle*

D42398

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42398

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 936 N. Eutaw ST. 11 WARD)

2-FULL NAME

(a) RESIDENCE. No. 936 N. Eutaw ST. 11 WARD.

(Usual place of abode)
Length of residence in city or town where death occurred 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed,
or Divorced (write the word)

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Emma Bow 1871

6 DATE OF BIRTH (month, day, and year)

7 AGE

49

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Shoemaker

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Elizabeth N. C.

10 NAME OF FATHER

Jim Bow Sr

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Hutcheon

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Hutcheon

14

Informant
(Address)

Mrs Emma Bow 936 N. Eutaw St

APR 20 1920

DECEASED & BURIED
Burial Permit 01234

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

WARD.

(If nonresident, give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18 1920

17 I HEREBY CERTIFY, That I attended deceased from
april 16, 1920, to april 18, 1920.

That I last saw him alive on april 17, 1920, at 8:20 a. m.

and that death occurred, on the date stated above, at 8:20 a. m.

The CAUSE OF DEATH* was as follows:

Uremia

CONTRIBUTORY
(Secondary)(duration) 1 yrs. 1 mos. 3 ds.
Nephritis about 3 mos. 4 ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Jno. H. Thompson, M. D.

(Address)

1019 Duval Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Laurel Cem.

Samuel D. Newby 5/8/20

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42399

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. ~~27~~ mos. 24 ds.

ST.: 6 WARD.

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

APR 20 1920

ROBERT R. FAUTER Registrar

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from April 13, 1920, to April 18, 1920, that I last saw him alive on April 18, 1920, and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:

Septic Sore Throat

CONTRIBUTORY (Secondary) Septic Bronchitis (duration) yrs. 3 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. F. Ruzicka

19 20 (Address) 800 N. Baltimore Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

Apr 20 1920

20 UNDERTAKER

Philip Henry

ADDRESS 2016

Orleans

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42400

CERTIFICATE OF DEATH

D42400

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant
(Address)

15

File

APR 20 1920

JOSEPH E. BRAUTER

Baptist Church

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov 19 1920, to April 17 1920.

that I last saw him alive on April 17 1920.

and that death occurred, on the date stated above, at 10 45 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate & Bladder

(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Yes Date of Nov 19/20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. H. M. D.

, 19 (Address) 805 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Philip Herwig

2016 Orleans

D42401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp* ST. *8* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *William Sickel*(a) RESIDENCE. No. *1425 E. Preston* ST. *8* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *34* yrs. mos. ds.(If nonresident give city or town and State)
How long in U. S., if of foreign birth? *34* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *white*5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Eleanor Sickel*6 DATE OF BIRTH (month, day, and year) *1886 Mar*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *34*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Bank Clerk*(b) General nature of industry, business, or establishment in which employed (or employer) *Old Tenn Nat. Bk.*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md.*10 NAME OF FATHER *John Sickel*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

14

Informant (Address) *Eleanor Sickel 1425 E. Preston*

15

APR 20 1920

ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-18* 19*20*17 I HEREBY CERTIFY, That I attended deceased from *March 27*, 19*20*, to *April 18*, 19*20*, that I last saw him live on *April 18*, 19*20*, and that death occurred, on the date stated above, at *10 30* a.m.
The CAUSE OF DEATH* was as follows:*(one)*
Myocardial infarction(duration) yrs. mos. ds. *1*CONTRIBUTORY (Secondary) *Empysem*(duration) yrs. mos. ds. *21*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *March 27-1920*Was there an autopsy? *no*What test confirmed diagnosis? *By operation*(Signed) *J. T. O'Brien*

, 19

(Address) *St. Joseph's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Greenmount*DATE OF BURIAL *Apr 20 1920*20 UNDERTAKER *Philip Herwig*ADDRESS *2016 Adams*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42402

D42402

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tobacco Stripper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

APR 20 1920

ROBERT A. CLATTER

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1920.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1920, to April 19, 1920, that I last saw him alive on April 19, 1920, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

CONTRIBUTORY (Secondary) (duration) 2 yrs. mos. ds. Broncho-pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test

(Signed)

19 (Address) City & Hospital, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

20 UNDERTAKER

Geo W Little

DATE OF BURIAL

April 21 1920

ADDRESS

531 St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42403

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3032 Elliott

2-FULL NAME

Mary E. Staps

(a) RESIDENCE. NO.

3032 Elliott

(Usual place of abode)

Length of residence in city or town where death occurred

Life

yrs.

ds.

ST.: WARD.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

William F. Staps

6 DATE OF BIRTH (month, day, and year)

Oct 17, 1863

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56

6

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Wilhelm Koningkramer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not known

14

Informant (Address)

William Staps
3032 Elliott

APR 20 1920

ROBERT E. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 18, 1920

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 15, 1919, to April 18, 1920,

that I last saw her alive on April 18, 1920,

and that death occurred, on the date stated above, at 4:45 A. M.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

CONTRIBUTORY (Secondary) Chronic nephritis (duration) yrs. 15 mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) J. B. Fitch, M. D.

420, 1920 (Address) 2500 So. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mount Carmel

DATE OF BURIAL

April 19, 1920

20 UNDERTAKER

H. Sander Nours

ADDRESS

1700 West

D42401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170

D42401

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *945 S. Second* ST.; *26* WARD)2-FULL NAME *Josephine Fischer*(a) RESIDENCE. No. *945 S. Second* ST.,

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Widowed</i>
------------------------	---------------------------------	--

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Sebastian Fischer*6 DATE OF BIRTH (month, day, and year) *Jan. 14, 1857*

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<i>69</i>	<i>3</i>	<i>3</i>	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Store Keeper*(b) General nature of industry, business, or establishment in which employed (or employer) *Grocery*

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto*
(State or country) *Md.*10 NAME OF FATHER *Martin E. Ehrman*11 BIRTHPLACE OF FATHER (city or town) *Germany*
(State or country)12 MAIDEN NAME OF MOTHER *Josephine Fischer*13 BIRTHPLACE OF MOTHER (city or town) *Germany*
(State or country)14 Informant *Margaret Fischer*
(Address) *945 S. Second St*15 *APR 20 1920* *ROBERT A. ELLIOTT*

Burial Permit 01078

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 17 1920*17 I HEREBY CERTIFY, That I attended deceased from *March 22*, 19*20*, to *April 17*, 19*20*.that I last saw her alive on *April 17*, 19*20*.and that death occurred, on the date stated above, at *8 P.* m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis(duration) *Indefinite* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted *Unknown*
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *H. B. Fitch*, M. D.19 *4/20*, 19*20*. (Address) *2504 St. Paul St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *St. Evangelical Church* DATE OF BURIAL *April 20 1920*20 UNDERTAKER *H. Sander Sons* ADDRESS *1710 North*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42405

CERTIFICATE OF DEATH.

D42405

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

442 Patapsco Ave ST.: 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elsie Dasey

(a) RESIDENCE. NO.

442 Patapsco Ave ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

20 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Joseph Dasey

6 DATE OF BIRTH (month, day, and year)

Oct 29, 1894

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

25

5

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Cambridge Maryland

10 NAME OF FATHER

William M. Hughes

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Elizabeth Ann

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

Joseph Dasey 442 Patapsco Ave

15

APR 20 1920

ROBERT E. BAUTER

Registrar

Social Permit 0101

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 18, 1920

17

I HEREBY CERTIFY, That I attended deceased from

Oct 22, 1920, to Apr 18, 1920,

that I last saw him alive on Apr 17, 1920,

and that death occurred, on the date stated above, at 9:10 A. M.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

CONTRIBUTORY (Secondary)

(duration) 6 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. B. Brook, M. D.

1920 (Address) 1-32 St. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill

April 18, 1920

20 UNDERTAKER

H. Sander Sons

ADDRESS

1210 N. Eads

D42406

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D42406
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 246 Bowes St. ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary McComas(Residence in Baltimore: No. 246 Bowes St. St.; 4 yrs., 4 mos., 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE, Col 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant6-DATE OF BIRTH, Jan 1920
(Month) (Day) (Year)7-AGE, 4 yrs., 4 mos., 4 ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Balto Md10-NAME OF FATHER, William McComas11-BIRTHPLACE OF FATHER (State or Country), Chesapeake Md12-MAIDEN NAME OF MOTHER, Rebecca Jones13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Hackett(Address) 117 N. Carroll15- ROBERT R. RAUTERFILED APR 20 1920 191... 0197
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 18, 191...
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 16 191... to April 18 191...
that I saw her alive on April 18 191...
and that death occurred, on the date stated above, at 1240 m.

The CAUSE OF DEATH* was as follows:

Acute Illness
(Duration).....yrs.....mos..2..ds.CONTRIBUTORY.....
(Secondary).....
(Signed) Dr. Hackett M. D.
4/19, 191... (Address) 117 N. Carroll

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Luke's April 20, 191...

20-UNDERTAKER ADDRESS

Daniel E. Egan 916

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42407

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1841 Penna ave* ST.; *14th* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Corinne Ediz Tate(Residence in Baltimore: No. *1841 Penna ave 3rd floor* St.: yrs. *3* mos. *27* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Female</i>	4-COLOR OR RACE, <i>Blk</i>	5-SINGLE, MARRIED, <i>Single</i> WIDOWED, OR DIVORCED, (Write the word.)
-------------------------	--------------------------------	--

6-DATE OF BIRTH, <i>December 28, 1919.</i> (Month) (Day) (Year)

7-AGE, <i>3 yrs. 3 mos. 27 ds.</i>	It LESS than 1 day,hrs. or....min.?
---------------------------------------	---

8-OCCUPATION: (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer).....	<i>In fact none</i>
--	---------------------

9-BIRTHPLACE, (State or Country), <i>Balt Md.</i>

PARENTS.	10-NAME OF FATHER, <i>Rollins Tate</i>
	11-BIRTHPLACE OF FATHER (State or Country), <i>Baltimore Md</i>
	12-MAIDEN NAME OF MOTHER <i>Sadie Emory</i>
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Baltimore Md</i>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sadie Tate*(Address) *1841 Penna ave*

15- APR 20 1920

Filed....., 191.....

ROBERT J. LEAVITT

Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, <i>April 19th, 1920.</i> (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 19th 1920*, to *Apr. 19th 1920*, that I saw her alive on *April 19th 1920*, and that death occurred, on the date stated above, at *2:30* m. The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia
(Duration) *From history* yrs. mos. *5* ds.

CONTRIBUTORY *Heart Pathemia*
(Secondary) (Duration) yrs. mos. *1* ds.

(Signed) *A. B. Glascock* M. D.
Apr. 19th, 1920 (Address) *1110 Madison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Ambrose**April 20, 1920*

20-UNDERTAKER

ADDRESS *916**Amel Easton**62 Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42408

CERTIFICATE OF DEATH.

28 D42408

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Fenwick(a) RESIDENCE. No. 1055 Argyle Ave.

ST. _____ WARD _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Unknown

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofJane Fenwick6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
49				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown9 BIRTHPLACE (city or town)
(State or country)Maryland10 NAME OF FATHER Clagette Fenwick11 BIRTHPLACE OF FATHER (city or town)
(State or country)Maryland12 MAIDEN NAME OF MOTHER Sarah Dorsey13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Maryland14 Informant Hospital Records
(Address) M.T.H.15 Filed APR 20 1920 ROBERT F. KLAUER
Serial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18, 192017 I HEREBY CERTIFY, That I attended deceased from
April 13, 1920, to April 18, 1920.that I last saw him alive on April 18, 1920,and that death occurred, on the date stated above, at 12:10 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 2 yrs. 4 mos. 10 ds.CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?Did an operation precede death? No Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? T.B. in sputum.(Signed) J. R. Wilkins M. D.4-19-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Tamara BenApril 21, 20

20 UNDERTAKER

ADDRESS

Daniel EarbyBe an

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42409

CERTIFICATE OF DEATH.

81

D42409

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1339 Ward ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Emily Mathews

(a) RESIDENCE. No.

1339 Ward

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 11 mos.

ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

James Mathews

6 DATE OF BIRTH (month, day, and year)

May 1835

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8411

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Geo. Washington Mathews

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Sophia Neal

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant (Address)

Nellie Nash
1336 Canvet St.

15

APR 20 1920

ROBERT B. LEATHER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 17, 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 14, 1920, to April 17, 1920,that I last saw him alive on Apr 16, 1920,and that death occurred, on the date stated above, at 8:30 A. M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Monkley Gray, M. D.4/18/20 Address 790 Lomb St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount AuburnApr 20 1920

20 UNDERTAKER

Daniel Easton

ADDRESS

Ba an

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *47 E. Church* ST. *22* WARD)REGISTERED NO. C. *150*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Rudolph Gross*(Residence in Baltimore: No. *47 E. Church* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male*4-COLOR OR RACE. *Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)6-DATE OF BIRTH, *Apr. 3, 1920*

(Month)

(Day)

(Year)

7-AGE, *17* yrs. mos. ds.

If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *none*(b) General nature of industry, business, or establishment in which employed (or employer) *000*9-BIRTHPLACE, *Baltimore*

(State or Country).

10-NAME OF FATHER, *Wm Gross*11-BIRTHPLACE OF FATHER, *Ind.*

(State or Country).

12-MAIDEN NAME OF MOTHER, *Mary Johnson*13-BIRTHPLACE OF MOTHER, *Ind.*

(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Gross*(Address) *47 E. Church St.*

15-

Filed *APR 20 1920*

ROBERT R. KRAUTER

BALTIMORE HEALTH DEPARTMENT
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Apr. 20, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Apr. 3, 1920*, to *Apr. 20, 1920*, that I saw him alive on *Apr. 19, 1920*, and that death occurred, on the date stated above, at *7:50* m.The CAUSE OF DEATH* was as follows:
Failure of closure of valve of heart

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) *E. Smith* M.D.*Apr. 20, 1920* (Address) *910 Light St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *My Auburn Ct*DATE OF BURIAL, *April 21, 1920*20-UNDERTAKER, *J. H. Brown & Son*ADDRESS, *108 W. Mount St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42411

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 W. Hanbury ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lizzie Brooks(Residence in Baltimore: No. 221 W. Hanbury St. St. 23 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

March 20, 1882
(Month) (Day) (Year)

7-AGE,

38 yrs. 7 mos. 29 da.If LESS than 1 day,
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)Domestic
0709-BIRTHPLACE,
(State or Country),Baltimore Md.

10-NAME OF FATHER,

Wm. Pinkney11-BIRTHPLACE OF FATHER
(State or Country),Not known

12-MAIDEN NAME OF MOTHER

Ellen Pinkney13-BIRTHPLACE OF MOTHER
(State or Country),Maine. Unity
not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Pinkney Jr.(Address) 907 Leadenhall St.

APR 20 1920

ROBERT R. KRAUTER

Filed..... 191.....

Baltimore City Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 18, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from March 30, 1920, to April 18, 1920, that I saw him alive on April 18, 1920, and that death occurred, on the date stated above, at 104 m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis due to exposure(Duration) 1 yrs. mos. da.CONTRIBUTORY
(Secondary)(Duration) 1 yrs. mos. da.(Signed) J. L. Shelton M. D.April 19, 1920 (Address) 208 W. Hanbury

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. da. In the State..... yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Int. Zion St

DATE OF BURIAL,

April 21, 1920

20-UNDERTAKER

J. H. Brown & Son

ADDRESS

108 W. Montg

D42412

HEALTH DEPARTMENT—CITY OF BALTIMORE D42412

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST. 25 WARD)

REGISTERED NO. C

2-FULL NAME Lydia Austin

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 245 Maryland Ave. Westport. St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-~~SEX~~ MARRIED Married (If divorced, give the word.)

6-DATE OF BIRTH, Dec 1st 1899, 1 (Month) (Day) (Year)

7-AGE, 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housework (b) General nature of industry, business, or establishment in which employed (or employer), 037

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (State or Country), do

12-MAIDEN NAME OF MOTHER, do

13-BIRTHPLACE OF MOTHER (State or Country), do

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....City..Hospital.....

(Address).....Bay..View..Hospital.....

15-

APR 20 1920 Filed 191... J. E. LAUTER Registrar.

Serial Permit 0121

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 18th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 24, 1920, to April 18th, 1920, that I saw her alive on April 18th, 1920, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pyelitis lithiasis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY Pyelitis nephritis (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Frank T. Barber M. D.

Apr 18, 1920 (Address) Bay View Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. 1 mos. 24 ds. In the State, 2 yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 245 Maryland Ave.

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill DATE OF BURIAL, April 20, 1920.

20-UNDERTAKER William Cook ADDRESS 602 S. North Ave.

Oliver M. Schmidt
HEALTH DEPARTMENT—CITY OF BALTIMORE

D42413

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD)

WARD.

(If nonresident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 9-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto md

10 NAME OF FATHER

Wm. Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto md

12 MAIDEN NAME OF MOTHER

Grace Sinner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto md

14

Informant (Address)

Wm. Schmidt

15

APR 20 1920

ROBERT E. KRAVITZ

Baltimore City

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 19 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 16, 1920, to April 19, 1920,

that I last saw him alive on April 19, 1920,

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry R. R. M. D.

19 Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Olivet

April 20 1920

20 UNDERTAKER

William Cook

ADDRESS

182 E. North Ave.

TION is very important. See instructions on back of certificate.

D42411

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hosp.*)ST.: *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mr. Ella Kaynie*(a) RESIDENCE. NO. *Morattus Co. Va.*

(Usual place of abode)

ST.:

WARD. *Morattus Va.*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. *1*mos. *14*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Elliott Kaynie*6 DATE OF BIRTH (month, day, and year) *8/6/89*

7 AGE

51

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Va.*10 NAME OF FATHER *T. Lewis Tinsley*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Va.*12 MAIDEN NAME OF MOTHER *Unkian*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Va.*

14

Informant
(Address)*Elliott C. Kaynie*
Morattus Va.

15

File

APR 20 1920

ROBERT B. KRAUTER

Regist. Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *7/20* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

3/7 19*20* to *7/20* 19*20*that I last saw him alive on *7/20* 19*20*and that death occurred, on the date stated above, at *1:00* p. m.

The CAUSE OF DEATH* was as follows:

*Cholecystitis & Appendicitis*CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *Yes* Date of *7/12/20*Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed)

Dr. R. R. Rye M. D.*7/20* 19*20* (Address) *Mary 1007*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Morattus Va.**4/24/20*

20 UNDERTAKER

Wm. Cook

ADDRESS

502 E. Matthews

TION is very important. See instructions on back of certificates.

Chauncy.
HEALTH DEPARTMENT—CITY OF BALTIMORE

D42415

CERTIFICATE OF DEATH.

D42415

PLACE OF DEATH

CITY OF BALTIMORE (No. 500 W. Mulberry St. 17

2-FULL NAME Leonard Chauncy

(Residence in Baltimore: No. 500 W. Mulberry

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 7 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Jan 17, 1869
(Month) (Day) (Year)

7-AGE,

50 yrs. 10 mos. 1 ds.

If LESS than 1 day,
hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Druggist

9-BIRTHPLACE,
(State or Country),

MD.

10-NAME OF FATHER,

John Chauncy

11-BIRTHPLACE OF FATHER
(State or Country),

B. C.

12-MAIDEN NAME OF MOTHER

S. Selinger

13-BIRTHPLACE OF MOTHER
(State or Country),

MD.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. Chauncy.

(Address) 1710 Montpelier St.

15-

Filed

101

ROBERT H. KRAUTH

APR 20 1920

Serial Form 101-101

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 18, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry,

thereon and from the evidence obtained by said inquest, autopsy or inquiry,

and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of illuminating gas
(Duration) 10 hrs.

CONTRIBUTORY (Secondary)

Suicide

(Duration) 10 yrs. 10 mos. 1 ds.

(Signed) J. H. Gorman, M. D.
(Coroner)

4-19-1920 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mount Carmel Cemetery April 20, 1920

20-UNDERTAKER

George J. Ruth 1735 Hayford Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42416

CERTIFICATE OF DEATH.

64 D42416

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Midvale Road; Roland Pk. ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sarah Jane Abrams

(a) RESIDENCE. No. 1 Midvale Road; Roland Pk. ST. WARD. 27
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louis H. Abrams6 DATE OF BIRTH (month, day, and year) July 26-1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
85		8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None9 BIRTHPLACE (city or town) Ohio
(State or country)10 NAME OF FATHER William Silcott11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)12 MAIDEN NAME OF MOTHER Sarah Viollette13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)14 Informant Martha Carter Perry
(Address) 8 Midvale Road; Roland Pk.15 Filed APR 20 1920 ROBERT H. KRAUTER Registrar
Burial Permit 01621

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 192017 I HEREBY CERTIFY, That I attended deceased from April 10, 1920, to April 18, 1920, that I last saw her alive on April 18, 1920, and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows:
ApoplexyCONTRIBUTORY (Secondary) Arterio sclerosis
(duration) 10 yrs. mos. ds.18 Where was disease contracted Home
if not at place of death?Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? clinical
(Signed) Wm. B. Case M. D.
, 19 (Address) 1 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Brownsville, Pa.

DATE OF BURIAL

4-20-20 19

20 UNDERTAKER

Chas. F. Evans & Son.

ADDRESS

118 West Mt. Royal

TION is very important. See instructions on back of certificates.

D42417

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42417

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mus. No. 1*)2-FULL NAME *George A. Talley*(a) RESIDENCE. No. *2411 N. Calvert*

(Usual place of abode)

Length of residence in city or town where death occurred *82* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1837*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

82

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Printer. 063

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Balto News Paper

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Mikna

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Mikna

12 MAIDEN NAME OF MOTHER

Mikna

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Mikna

14

Informant (Address)

Chas H. Hynes - 3412 Lumball Ave

15

APR 20 1920

ROBERT E. ELAETER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *7/14* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

1/24, 19*20*, to *7/14*, 19*20*.that I last saw him alive on *7/14*, 19*20*.and that death occurred, on the date stated above, at *12 noon* m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Wm. D. Rader* M. D.*7/14* 19*20* (Address) *Mus. No. 1*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Louisa Park

DATE OF BURIAL

Apr 21 1920

20 UNDERTAKER

W. L. Talley

ADDRESS

Mus. No. 1

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42418

CERTIFICATE OF DEATH.

45
REGISTERED NO. C

D42418

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 N. Bradford ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1618 N. Bradford St.; 44 yrs., 9 mos., 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

July 12, 1875
(Month) (Day) (Year)

7-AGE,

44 yrs., 9 mos., 8 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Michael Soltz

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Martha Schwartzkopf

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-APR 20 1920

Filed..... 191.....

ROBERT K. KRAUTH

JULIUS FRYMANT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Oct 17, 1910, to April 20, 1920,
that I saw him alive on April 17, 1920,
and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Enlargement of Papanov's gland
and enlargement of glands
(Duration).....yrs...7...mos.....ds.

CONTRIBUTORY (Secondary)

General Laccination
(Duration).....yrs...2...mos...14...ds.
(Signed).....Herbert M. Foster, M. D.
April 20, 1920 (Address).....114 W. Middle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Church

DATE OF BURIAL,

Apr. 23, 1920

20-UNDERTAKER

Henry Woodbury

ADDRESS

1301 E. Eager St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42419

CERTIFICATE OF DEATH.

155 D42419
REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Franklin J. Howard* ST. *AB* WARD)2-FULL NAME *Easter P. H. Powers*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *601 Dukeland Ave* St. *5* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *white*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *Apr 2, 1899*
(Month) (Day) (Year)7-AGE, *21* yrs. - *17* mos. *17* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *domestic*
(b) General nature of industry, business, or establishment in which employed (or employer), *070*9-BIRTHPLACE, *md*
(State or Country),10-NAME OF FATHER, *Robt H. Cusker*11-BIRTHPLACE OF FATHER, *unknown*
(State or Country),12-MAIDEN NAME OF MOTHER, *Nellie Grant*13-BIRTHPLACE OF MOTHER, *md*
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Easter P. H. Powers*(Address) *601 Dukeland Ave*

15-APR 20 1920

ROBERT B. KRAUTER

Filed

191

Baltimore City Health Department

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Apr 19, 1920*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*
(Inquest, autopsy or inquiry)thereon and from the evidence obtained by said *inquest*
(Inquest, autopsy or inquiry) had that said deceased came to death of the day stated above.

The CAUSE OF DEATH* was as follows:

Beckton's Poisoning

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *J. Edgar Smith* M. D.

(Coroner)

1920 (Address) *710 Light St*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cumberland Md.*DATE OF BURIAL, *April 21, 1920*

20-UNDERTAKER

ADDRESS

Geo. A. Herbig 2001 W. Baltimore St

important. See instructions on back of certificate.

D42420

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D42420

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1444 Elmwood ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Hartline

(a) RESIDENCE. NO.

1444 Elmwood

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John H Hartline

6 DATE OF BIRTH (month, day, and year)

Sept 1 - 1849

7 AGE

70

Years

Months

18

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md

10 NAME OF FATHER

Henry Dickert

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Bloch

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Katherine Hartline
1444 Elmwood

15

Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 18 1920

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 - 1920, to April 18 1920, that I last saw her alive on April 18 1920, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

not known

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Bacterium Tuberc

(Signed)

Alvin B. Leman

M. D.

Address 718 N. Pallen St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Trinity CemeteryApr 21 1920

20 UNDERTAKER

John Dickert

ADDRESS

2008 Calver

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

APR 20 1920

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42421

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2232 Linden Ave ST.; 13 WARD)2-FULL NAME Max Musbaum(a) RESIDENCE. NO. 2232 Linden Ave ST.,

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Minnie G. Musbaum6 DATE OF BIRTH (month, day, and year) Nov 20 1868

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

375

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer)

Manager of Mutual Bank

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Norfolk Va10 NAME OF FATHER Louis Musbaum

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany12 MAIDEN NAME OF MOTHER Betty Goldsmith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland

PARENTS

14 Informant (Address)

J. H. Crutcher 2232 Linden Ave

15 Filed

Robert P. Harrison,

Registrar

APR 20 1920

Marcel Fernat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 13, 1920, to April 19, 1920,that I last saw him alive on April 19, 1920,and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Thrombus of Coronary artery & Pulmonary infarct(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 6 ds.18 Where was disease contracted if not at place of death? CityDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Observation

(Signed)

Joseph J. Fisher, M. D.

19 (Address)

1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew BurialApril 21 1920

20 UNDERTAKER

ADDRESS

David Southerin1184 Mt Royal

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42422

CERTIFICATE OF DEATH.

D42422

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Greenway & Thirty-fifth. ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kathleen Janet Riordan(a) RESIDENCE. No. Greenway & Thirty-fifth. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 8 mos. 18 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofWilliam A. Riordan6 DATE OF BIRTH (month, day, and year) Aug 12 18717 AGE 49 Years 8 Months 18 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)10 NAME OF FATHER Samuel V. Kitson11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)12 MAIDEN NAME OF MOTHER Kate A. Flynn13 BIRTHPLACE OF MOTHER (city or town) Richmond, Va.
(State or country)14 Informant William A. Riordan
(Address) Greenway & 35th St.15 Filed Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19 192017 I HEREBY CERTIFY, That I attended deceased from Jan 18 to April 19, 1920.that I last saw her alive on April 19, 1920, and that death occurred, on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
and hypertension(duration) 5 yrs. 0 mos. 0 ds.CONTRIBUTORY (Secondary) Apoplexy(duration) yrs. mos. ds. 2

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of -Was there an autopsy? NoWhat test confirmed diagnosis? All clinical signs(Signed) Jules Friedman, M. D.Address) 1013 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery4/21, 1920

20 UNDERTAKER

ADDRESS

Henry W. Mears & Son 805 W. Calvert St.

TION is very important. See instructions on back of certificates.

APR 20 1920

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42423

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hosp.* ST. *17* WARD)2-FULL NAME *Mr. Mary Virginia Abraham*(a) RESIDENCE. No. *109 N. Fremont* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *60* yrs. *10* mos. *27* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 24th 1859*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*60**10**27*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Saltsville, Md.*10 NAME OF FATHER *Steven Doodlent*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*England*12 MAIDEN NAME OF MOTHER *Mary B. Scott*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

14

Informant (Address)

Mary Hospital Record

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 20* 19 *20*17 I HEREBY CERTIFY, That I attended deceased from *April 18*, 19 *20*, to *April 20*, 19 *20*, that I last saw him alive on *April 20*, 19 *20*, and that death occurred, on the date stated above, at *3* *PM* m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Neoplasm + Chronic Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Wm. D. Rigby*, M. D.yrs. 19 (Address) *Mary Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Green Mount Cemetery**April 21* 19 *20*

20 UNDERTAKER

ADDRESS

Henry W. Meador 805 Calvert

APR 20 1920

Burial Permit Clerk

Registrar

D42421

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42421

REGISTERED NO. C

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>male</i>	4-COLOR OR RACE, <i>Black</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, <i>Foundling</i>		
7-AGE, <i>about 4 mos. old</i>		
8-OCCUPATION: (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer).....		
9-BIRTHPLACE, (State or Country), <i>Foundling</i>		

PARENTS.	10-NAME OF FATHER,
	11-BIRTHPLACE OF FATHER (State or Country),
	12-MAIDEN NAME OF MOTHER
	13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Robert P. Harrison, CHNS

APR 20 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 19, 191²⁰

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *January* 191²⁰, to *April* 191²⁰, that I saw him alive on *April 17* 191²⁰, and that death occurred, on the date stated above, at *3 A.* m.

The CAUSE OF DEATH* was as follows:

Intestinal Decomposition

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Signed) *Frank J. Ayer* M. D.
Apr 19, 1920 (Address) *2005 E. Monument St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

HOPKINS HOSPITAL

DATE OF BURIAL,

....., 191²⁰

20-UNDERTAKER

Commissioner Health,

ADDRESS

APR 20 1920

D42425

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42425

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Temple

ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Spry

(a) RESIDENCE. No. 8 Temple

(Usual place of abode)

ST.: 5 WARD.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female Colored Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1875

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

45

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

live in Balt 20 years Del.

10 NAME OF FATHER

Thomas Spry

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Del.

12 MAIDEN NAME OF MOTHER

Mancy Ferguson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Del.

14

Informant (Address)

Howard F. Harrison Del.

15

FRI

Robert P. Harrison,

Registrar

PR20 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17, 1920

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1920, to April 17, 1920, that I last saw her alive on April 17, 1920, and that death occurred, on the date stated above, at 7-15-0, m. The CAUSE OF DEATH* was as follows:

Brucellosis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Robt. F. Green, M. D.

4-19, 1920 (Address) 120 1/2 Cisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Ashbury Cem

April 21, 1920

20 UNDERTAKER

ADDRESS

Mrs R A Elliott Ashland

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42426

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Baltimore Md.

REGISTERED No. C

CITY OF BALTIMORE: (No.

1420 Park Ave

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Inogene Berry Payne

(Residence in Baltimore: No.

1420 Park Ave

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

June

(Month)

21st 1851

(Day)

(Year)

7-AGE,

68 yrs.

9 mos.

28 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

10-NAME OF FATHER,

John H. Berry

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Louisa Fanny West

13-BIRTHPLACE OF MOTHER

(State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

G. Harrison Payne Jr.

(Address)

1420 Park Ave

15-

APR 20 1920

Robert P. Harrison,

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 19, 1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from

June 1919, to April 1920,

that I saw h alive on April 19 1920

and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic enteritis

(Duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary)

Stomach inability

(Duration) yrs. 6 mos. ds.

(Signed)

C. C. Harrison, M. D.

April 20, 1920

(Address) 1008 Calhoun St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Greenmount Cem

April 21, 1920

20-UNDERTAKER

ADDRESS

Henry A. Jenkins & Son

McClulloh Richard St.

D42427

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42427

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Robinson(a) RESIDENCE. NO. 110 Myrtle Ave.

ST. _____ WARD _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1903

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.17

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workHousework(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore,Maryland

10 NAME OF FATHER

Wm. Robinson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

South Carolina

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore
Maryland

14

Informant
(Address)Hospital RecordsM.T.H.

15

Filed

19

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18, 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 14, 1920, to April 18, 1920,that I last saw her alive on April 18, 1920,and that death occurred, on the date stated above, at 5.50 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) _____ yrs. 8 mos. _____ ds.CONTRIBUTORY Tuberculous entero-colitis
(Secondary)(duration) _____ yrs. 1 mos. _____ ds.18 Where was disease contracted
if not at place of death?UnknownDid an operation precede death? No Date of _____

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum.

(Signed)

George R. Wilkerson, M. D.

4-19-20

(Address) Municipal Tuberculosis Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel CemeteryApr 20 19

20 UNDERTAKER

ADDRESS

George H. Holland 163 W. 18th St.Billany

APR 20 1920

Burial Permit Clark

TION is very important. See instructions on back of certificates.

D42428

Graves
HEALTH DEPARTMENT—CITY OF BALTIMORE

D42428

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 Winchester ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1423 Winchester St.; 10 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Caucasian

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH.

July 31, 1900
(Month) (Day) (Year)

7-AGE.

19 yrs. 8 mos. 19 ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer 040
Day labor

9-BIRTHPLACE, (State or Country).

North London

10-NAME OF FATHER.

Alfred Groves

11-BIRTHPLACE OF FATHER (State or Country).

N. L.

12-MAIDEN NAME OF MOTHER

Martha Jeffers

13-BIRTHPLACE OF MOTHER (State or Country).

N. L.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Robert P. Harrison, Jr.

(Address)...

1423 Winchester

15-

Robert P. Harrison,

APR 20 1920

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Apr. 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 8 - 1920, to Apr. 18 - 1920, that I saw him alive on Apr. 18 - 1920, and that death occurred, on the date stated above, at 4-9+ m. The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) ... yrs. ... mos. 12 ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. 2 ds.

(Signed) ... M. D.

Apr. 19, 1920 (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Mt Auburn Cem

DATE OF BURIAL.

Apr. 20, 1920

20-UNDERTAKER

George T. A. Gibson

ADDRESS

513 Laurel St

D42429

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42429

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *625 East Ave*)ST. *24* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Lillian Jones

(a) RESIDENCE. NO.

625 East Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *25* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

*Widow*5a ~~Married~~ married, widowed, or divorcedHUSBAND of
(or) WIFE of*Thos H. Jones*

6 DATE OF BIRTH (month, day, and year)

Aug. 22, 1888

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*64**7**27*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country)

Green Anne Co Maryland

10 NAME OF FATHER

Gideon Harris

11 BIRTHPLACE OF FATHER (city or town, State or country)

Eastern Shore of Md.

12 MAIDEN NAME OF MOTHER

Mary Busted

13 BIRTHPLACE OF MOTHER (city or town, State or country)

Eastern Shore of Md.

14

Informant
(Address)*Thos G. Jones
1625 East Ave*

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 18* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from
Apr. 11, 19 *20*, to *Apr. 18*, 19 *20*,
that I last saw her alive on *Apr. 18*, 19 *20*,
and that death occurred, on the date stated above, at *7:00 P. M.*
The CAUSE OF DEATH* was as follows:*Apooplexy*(duration) yrs. mos. *1* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

Wm. T. Seabury

M. D.

Apr. 18, 1920 (Address) *625 East Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Western Cem.**April 21 1920*

20 UNDERTAKER

M. S. Flynn

ADDRESS

1422 Light

TION is very important. See instructions on back of certificates.

APR 20 1920

042430

HEALTH DEPARTMENT—CITY OF BALTIMORE

042430

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 William St. ST.: 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1037 William St. St.: 24 yrs., 1 mos., 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Child

6-DATE OF BIRTH,

April

19th

1920

7-AGE,

yrs. mos. ds.

If LESS than 1 day,
9 hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

Elyah Adams

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Dora Kramer

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Elyah E. Adams

(Address)

1037 William St.

15-

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 19th

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 19th 1920 to April 20th 1920

that I saw him alive on April 20th 1920

and that death occurred, on the date stated above, at 8:00 m.

The CAUSE OF DEATH* was as follows:

Deficient Circulatory System
 Blue Stain
 (Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) John P. Holt M. D.

April 20th 1920 (Address) 1203 Light

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cedar Hill Cemetery

April 21st 1920

20-UNDERTAKER

ADDRESS 1037

E. Schuman & Son

Baltimore

APR 20 1920

D42431

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42431

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1137 Hammer ST. 23 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1137 Hammer St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH

Nov. 18, 1920
(Month) (Day) (Year)

7-AGE

74 yrs. 4 mos. 29 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Spouse duties
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country)

Baltimore Md

10-NAME OF FATHER

Christian Gitz

11-BIRTHPLACE OF FATHER (State or Country)

Germany

12-MAIDEN NAME OF MOTHER

Mary M. Harris

13-BIRTHPLACE OF MOTHER (State or Country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy Gitz(Address) 1137 Hammer St

15-

Robert F. Harrison,

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

April 19, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 10, 1920, to April 19, 1920, that I saw her alive on April 14, 1920, and that death occurred, on the date stated above, at 4 P. M. The CAUSE OF DEATH* was as follows:
Senile myocarditis

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. 10(Signed) E. Schuman M. D.Apr. 16, 1920 (Address) E. Schuman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

April 22, 1920

20-UNDERTAKER

E. Schuman & Son

ADDRESS

1039 Hammer St

CAUSE OF DEATH in plain terms, so that it may be properly translated. Important. See instructions on back of certificate.

APR 20 1920

D42432

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 172 D42432

PLACE OF DEATH South Plant, Balto. Dry docks
CITY OF BALTIMORE (No. & Ship building Co. ST. 22

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Victor Webster.

(Residence in Baltimore: No. 524 Hanover St.

St.: yrs. 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)

6-DATE OF BIRTH, Do not know, 1 (Month) (Day) (Year)

7-AGE, 58 yrs. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Carpenter. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Mt. Vernon Somerset Co. Md.

10-NAME OF FATHER, Joseph Webster.

11-BIRTHPLACE OF FATHER (State or Country), Somerset Co. Md.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas W. Young. (brother in law)
(Address) 546 N. Paluski St.

15- Robert F. Harrison,

APR 20 1920 Filed 191 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 20th, 1920, 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidental fall from a ship.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) Otto M. Reinhardt M. D. (Coroner) Apr. 20, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence Somerset Co. Md.

19-PLACE OF BURIAL OR REMOVAL, Princess Anne Md. DATE OF BURIAL, APR 20 1920.

20-UNDERTAKER, JOHN F. DENNY ADDRESS, 716 LIGHT ST.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42433

CERTIFICATE OF DEATH.

175

D42433

PLACE OF DEATH

CITY OF BALTIMORE (No. _____)

REGISTERED NO. C. _____

2-FULL NAME

(Residence in Baltimore: No. _____)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

....., 1.....
(Month) (Day) (Year)

7-AGE,

3 yrs. 6 mos. da.

If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

FILED

APR 21 1920

ROBERT E. KAUTER

Bureau of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 19, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.)

the body and from the evidence obtained by said Inquest, au-

topsy or inquiry.) I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chambers, Jr.,
Automobile.

(Duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. da.

(Signed) J. H. Insler, M. D.

4-20, 1920 (Address) T. Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Hebrew Burial Society

20-UNDERTAKER

May Simon

DATE OF BURIAL,

April 21, 1920

ADDRESS

1127 E
Balto. St.

important. See instructions on back of certificate.

N. B.-Every item of information should be carefully verified before being entered on this certificate. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE
CERTIFICATE OF DEATH

REGISTERED NO. C

D42431
PLACE OF DEATH

CITY OF BALTIMORE (No. 3106 Baker St. ST. 16 WARD)

2-FULL NAME

James Edward Landauer
(Residence in Baltimore: No. 3106 Baker St. St. 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Nov 11, 1850
(Month) (Day) (Year)

7 AGE

69 yrs. 5 mos. 8 ds. If less than 1 day, hrs. or min.

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Salesman 066

9 BIRTHPLACE
(State or country)

France

10 NAME OF FATHER

James Edward Landauer

11 BIRTHPLACE OF FATHER
(State or country)

France

12 MAIDEN NAME OF MOTHER

Louise Hagen

13 BIRTHPLACE OF MOTHER
(State or country)

France

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. H. Landauer

(Address)

3004 Presbury St.

15

APR 21 1920

ROBERT H. KRAUTER

DEATH RECORD

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 19, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18, 1920, to April 19, 1920, that I saw him alive on April 18, 1920, and that death occurred, on the date stated above, at 6:40 A.M. The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

Contributory (SECONDARY)

Cardiac Asthma
(Duration) yrs. mos. ds.

(Signed) Herbert E. Zepher M. D.
April 19, 1920 (Address) 3050 N. York Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted?
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Forest Lawn Co.

DATE OF BURIAL

April 21, 1920

20 UNDERTAKER

Joseph B. Cook 1003 N. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42436

CERTIFICATE OF DEATH.

104 D42436
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 S Ann ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leon Norton

(Residence in Baltimore: No. 604 S Ann St. yrs. 5 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH, November 2, 1919 (Month) (Day) (Year)

7-AGE, yrs. 5 mos. 17 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, none (b) General nature of industry, business, or establishment in which employed (or employer), 000

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, Lester Norton

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, male Popiotek

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) male Norton

(Address) 604 S Ann St.

15- APR 21 1920

ROBERT E. KRAUTER

Filed, 191. Burial in Registry

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 19, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 18, 1920, to April 19, 1920, that I saw him alive on April 19, 1920, and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Diarrhea (Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Indigestion (Duration) yrs. mos. 8 ds.

(Signed) St. Stanislaus P. M. D. April 19, 1920. (Address) 722 S Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. Is the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus DATE OF BURIAL, April 21, 1920

20-UNDERTAKER, William Galford ADDRESS, 168 Eastern Ave.

Important. See instructions on back of certificate.

D42437

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42437

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7135 Port

ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Agnes Idzi

(a) RESIDENCE. NO.

713 1 Port

ST.: 1 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

DEC 16 1917

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

4

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Francis Idzi

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Prussia Poland

12 MAIDEN NAME OF MOTHER

Mary Idzi

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

14

Informant (Address)

Mary Idzi 713 S. Port St

15

Filed

APR 21 1920

ROBERT A. KAUTER

Boris Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 20 1920

17

I HEREBY CERTIFY, That I attended deceased from

4-16, 1920, to 4-20, 1920,

that I last saw her alive on 4-20, 1920,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Subs. Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) J. A. B. M. D.

, 19 (Address) 1623 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus

Apr 22 1920

20 UNDERTAKER

M. F. Sadowski

ADDRESS

700 S. Ave

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42438

CERTIFICATE OF DEATH.

120 42438

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1636 Grouse Cr. ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Frederick A. Walden

(a) RESIDENCE. No.

1636 Grouse Cr. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

40 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofLouise Walden

6 DATE OF BIRTH (month, day, and year)

Apr 6 1857

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

6313

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Rudolph Walden

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Emily Stube

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant
(Address)Arthur F. Walden
525- Richmond Cr.

15

Filed

19

APR 21 1920

ROBERT A. LEAUTEK

Barial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-191920

17

I HEREBY CERTIFY, That I attended deceased from

April 101920, toApril 181920

that I last saw him alive on

April 181920

and that death occurred, on the date stated above, at

3-10 P.

m.

The CAUSE OF DEATH* was as follows:

Cerebral Edema

(duration)

yrs.

mos.

3

ds.

CONTRIBUTORY (Secondary)

Arterio Sclerosis, Ch. respiratory

(duration)

yrs.

mos.

4

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical findings

(Signed)

Michael A. Hume

M. D.

19 (Address)

#2360 Eutan place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

WoodlawnApr 22 1920

20 UNDERTAKER

ADDRESS

H. M. CorleH. M. Corle

TION is very important. See instructions on back of certificates.

D42439

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42439

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *248 S. E. St.*

St.:

WARD) *3*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

2-FULL NAME

John Bertarelli(Residence in Baltimore: No. *248 S. E. St.*St.; *15* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Married*

6-DATE OF BIRTH,

October 28, 1864
(Month) (Day) (Year)

7-AGE,

56 yrs. *6* mos. *20* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Driver of 023
horse-car.*9-BIRTHPLACE,
(State or Country),*Italy*

10-NAME OF FATHER,

*Pietro Bertarelli*11-BIRTHPLACE OF FATHER
(State or Country),*Italy*

12-MAIDEN NAME OF MOTHER

*Angela Bertarelli*13-BIRTHPLACE OF MOTHER
(State or Country),*Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph Bertarelli*(Address) *1003 Fawn St.*

15-

APR 21 1920

ROBERT H. KAUTER

Filed

191

Burial in the

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 20, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Jan 1, 1910*, to *April 20, 1920*, that I saw him alive on *April 20 - 1920*, and that death occurred, on the date stated above, at *3:30 A.M.*

The CAUSE OF DEATH* was as follows:

Gastric Ulcer(Duration) *10* yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Eugene P. Serrano* M. D.*April 20, 1920* (Address) *2314 E. B. St. N.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Vincent

DATE OF BURIAL,

April 23, 1920

20-UNDERTAKER

Wendell B. Appleton

ADDRESS

378 N. Main St.

D42440

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D42440

1 PLACE OF DEATH

CITY OF BALTIMORE: (No

2960 Harford Ave

ST.

WARD) 9

2-FULL NAME

Catherine P. Clancy

(Residence in Baltimore: No.

2960 Harford Ave

St.; Life yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

f

4-COLOR OR RACE

W

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

July

3

1897

7-AGE

22

yrs.

7

mos.

14

ds.

or

min.?

If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

at home

9-BIRTHPLACE
(State or country)

Baltimore

PARENTS

10-NAME OF FATHER

Jno J Clancy

11-BIRTHPLACE OF FATHER
(State or country)

Baltimore

12-MAIDEN NAME OF MOTHER

Lohanna J. Fahy

13-BIRTHPLACE OF MOTHER
(State or country)

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John J. Clancy
2960 Harford Ave.

15-

APR 21 1920

ROBERT F. LEAUTER

BIRTH PLACE REGISTER

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

April

17

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 1, 1920, to April 15, 1920,

that I saw her alive on April 15, 1920,

and that death occurred, on the date stated above, at 7 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration)

2

yrs.

mos.

ds.

Contributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed),

Apr 17, 1920

[Address]

2700 Harford Ave

M. D.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death

yrs.

mos.

ds.

In the

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Catholic Church

April 22, 1920

20-UNDERTAKER

ADDRESS

George F. Ruth

735 Harford Ave

State CAUSE OF DEATH in plain terms, so far as possible, on back of certificate. See instructions on back of certificate. TION is very important.

D42441

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* ST.: *18* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *113 S Poppleton* ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *4* yrs. mos. ds. How long in U. S., if of foreign birth? *8* yrs. *5* mos. *15* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Single</i>
5a If married, widowed, or divorced HUSBAND of (or) WIFE of		
6 DATE OF BIRTH (month, day, and year) <i>Nov. 4 1911</i>		
7 AGE <i>8</i> Years	Months <i>5</i>	Days <i>15</i>
		If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address)

15

Filed

19

APR 21 1920

ROBERT F. KLAUTER

Basis Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 19 1920*

17

I HEREBY CERTIFY, That I attended deceased from *April 12, 1920*, to *April 19, 1920*, that I last saw him alive on *April 19, 1920*, and that death occurred, on the date stated above, at *2:30 P.* m.

The CAUSE OF DEATH* was as follows:

Lung Abscess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *113 S. Poppleton*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *J. W. Montcalm* M. D.19 (Address) *Mary Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Peter's Church**4/23/1920*

20 UNDERTAKER

ADDRESS

*John J. Cawson & Son**York Hall*

CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42442

D42442

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *409 N Fremont* ST.; *17* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Anna and J. Howard*(Residence in Baltimore: No. *409 413 N Fremont* St.; *5* yrs., *0* mos., *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE, *C*5-SINGLE, *Mar.*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *Jan 13*, 186*6*

(Month)

(Day)

(Year)

7-AGE, *59*

yrs.

mos.

da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer), *039*

9-BIRTHPLACE,

(State or Country), *Baltimore Md*10-NAME OF FATHER, *Abram Ruster*11-BIRTHPLACE OF FATHER (State or Country), *Md*12-MAIDEN NAME OF MOTHER, *Charlie Anna Porter*13-BIRTHPLACE OF MOTHER (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Mellen Howard*(Address), *409 N Fremont*

15-APR 21 1920

ROBERT E. KAUTER

Filed

191

Baltimore City Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Apr 19*, 191*2*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Apr 13* 191*2*, to *Apr 19* 191*2*,that I saw h alive on *Apr 17* 191*2*,and that death occurred, on the date stated above, at *5 P* m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) yrs. *10* mos. *10* ds.CONTRIBUTORY (Secondary) *Pulm Oedema*(Duration) yrs. *2* mos. *2* ds.(Signed) *J. Howard* M. D.*Apr 19*, 191*2* (Address) *93 N Taylor*

*State the DISEASE CAUSE OF DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *0* mos. *0* ds. In the State yrs. *0* mos. *0* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *My Auburn*DATE OF BURIAL, *Apr 22* 192020-UNDERTAKER, *Mr. H. Toadwin*ADDRESS *143 W. Hill St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42443

CERTIFICATE OF DEATH.

92
REGISTERED NO. C

D42443

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 W. West ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kerame Wise(Residence in Baltimore: No. 524 W. West St.; 8 yrs. 8 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word)
Single

6-DATE OF BIRTH,

Aug 6, 1910
(Month) (Day) (Year)

7-AGE,

8 yrs. 8 mos. 13 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),Balt.

10-NAME OF FATHER,

Edu. Wise11-BIRTHPLACE OF FATHER
(State or Country),md

12-MAIDEN NAME OF MOTHER

Ellie Fletcher13-BIRTHPLACE OF MOTHER
(State or Country),md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellie Wise(Address) 524 W. West St.

15-

APR 21 1920

ROBERT F. KRAUTER

BRIEF PERMITS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 19, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 12 1920, to April 19 1920, that I saw him alive on April 18 1920, and that death occurred, on the date stated above, at 11:15 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration)....yrs....mos....ds.

CONTRIBUTORY
(Secondary)

(Duration)....yrs....mos....ds.

(Signed) C. H. Hare M. D.April 20, 1920 (Address) 712 S. Hamp. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Int. Auburn

DATE OF BURIAL,

4-23, 1920

20-UNDERTAKER

John H. Loeber

ADDRESS

142 W. 1st St.

D42441

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42441

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1632 W. Fayette St., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1632 W. Fayette St., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) wife of

6 DATE OF BIRTH (month, day, and year) May 30, 1853

7 AGE Years 66 Months 10 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14

Informant (Address)

15

APR 21 1920

ROBERT K. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15, 1920

17

I HEREBY CERTIFY, That I attended deceased from

Dec. 1914, to April 1920,

that I last saw him alive on April 17, 1920,

and that death occurred, on the date stated above, at 2:45 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

827 P. B. B. (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill Cem

4 22 1920

20 UNDERTAKER

ADDRESS

Chas. J. Evans & Son 118 W. Mt. Royal Ave

See instructions on back of certificates.

D42445

HEALTH DEPARTMENT CITY OF BALTIMORE

D42445

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 325 Carrollton Ave. ST.; 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 325 Carrollton Ave. St.; 18 yrs., 10 mos., 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH,

Mar (Month) 25 (Day) 1858 (Year)

7-AGE,

62 yrs., 2 mos., 26 ds.If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Brass Moulder
(b) General nature of industry, business, or establishment in which employed (or employer). Retired 010

9-BIRTHPLACE, (State or Country),

Balto

10-NAME OF FATHER,

William H Lloyd

11-BIRTHPLACE OF FATHER (State or Country),

New York

12-MAIDEN NAME OF MOTHER

Mary Keller

13-BIRTHPLACE OF MOTHER (State or Country),

Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Lloyd(Address) 325 Carrollton Ave.

15-APR 21 1920

Filed. 191 ROBERT F. KAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr (Month) 20 (Day) 1918 (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Nov 15 1919, to Apr 20 19120,that I saw him alive on Apr 18 19120,and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Asphyxia
(Duration) 10 yrs., 10 mos., 20 ds.

CONTRIBUTORY (Secondary)

(Signed) Wm Lloyd M. D.
1918 (Address) 1352 Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 10 yrs., 10 mos., 20 ds. In the State 10 yrs., 10 mos., 20 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Balto Cemetery

DATE OF BURIAL.

Apr 21, 19120

20-UNDERTAKER

John Fields

ADDRESS

1200 N. Lombard

important. See instructions on back of certificate.

N. B.-Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42446

CERTIFICATE OF DEATH

9-891 D42446

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *Sydenham Hospital*)

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *George Wong*

(Residence in Baltimore: No. *428 South Broadway* St. *3* yrs. *3* mos. *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

male Chinese

single

6-DATE OF BIRTH

Jan. 15, 1917
(Month) (Day) (Year)

7-AGE

3 yrs. *3* mos. *6* ds.

If LESS than 1 day, --- hrs. or --- min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

infant

9-BIRTHPLACE (State or country)

Ud.

10-NAME OF FATHER

Hong Weh

11-BIRTHPLACE OF FATHER (State or country)

China

12-MAIDEN NAME OF MOTHER

Lee Shee

13-BIRTHPLACE OF MOTHER (State or country)

China

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chin Suon

(Address)

114 Park Ave.

APR 21 1920

ROBERT E. KRAUTER

Filed

191

BORIS P. ... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

April 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 20, 1920* to *April 21, 1920*, that I saw him alive on *April 21, 1920*, and that death occurred, on the date stated above, at *5:45 a.m.* The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(Duration) --- yrs. --- mos. *3* ds.

Contributory (SECONDARY)

Broncho pneumonia

(Duration) --- yrs. --- mos. *2* ds.

(Signed)

Billacrae M.D.

April 21, 1920

(Address) *Sydenham Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death --- yrs. --- mos. *1* ds. State --- yrs. --- mos. --- ds.

Where was disease contracted,

if not at place of death?

at home

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Baltimore

DATE OF BURIAL

Apr 21, 1920

20-UNDERTAKER

Go Mitchell

ADDRESS

2701 W. Gay St.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42448

CERTIFICATE OF DEATH

79 D42448

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 10521 Hayward Ave. ST. 27 WARD)

2-FULL NAME William E. Nagle Jr.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 10521 Hayward Ave. St. 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

November 14, 1875
(Month) (Day) (Year)

7-AGE

44 yrs. 5 mos. 5 ds. If LESS than 1 day, hrs. min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

OIS

9-BIRTHPLACE
(State or country)

Baltimore, Md.

PARENTS

10-NAME OF FATHER

William E. Nagle

11-BIRTHPLACE OF FATHER
(State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Margaret Fizzle

13-BIRTHPLACE OF MOTHER
(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carrie E. Nagle

(Address)

10521 Hayward Ave.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

April 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1920, to April 19, 1920,

that I saw him alive on April 15, 1920, and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Contributory
(SECONDARY)

Coronary Sclerosis

(Signed)

William P. Hest April 20, 1920. [Address] 10715 Ave.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery April 21, 1920

20-UNDERTAKER

ADDRESS

Linton P. Fussellbaugh 2620 H. Paul St.

15-

* ROBERT E. KRAUTER

APR 21 1920

Burial Form REG-100

STATE CAUSE OF DEATH IN plain terms. See instructions on back of certificate.

D42449

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42449

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3314 Fleet St.*ST.; *26* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

May Schatz.(Residence in Baltimore: No. *3314 Fleet St.*

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Single

6-DATE OF BIRTH,

April 20, 1920
(Month) (Day) (Year)

7-AGE,

..... yrs. mos. ds.

If LESS than 1 day,
..... hrs. or 10 min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),*Baltimore City*

10-NAME OF FATHER,

*Andrew Schatz*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore City*

12-MAIDEN NAME OF MOTHER

*Lillian Young*13-BIRTHPLACE OF MOTHER
(State or Country),*Baltimore City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Andrew Schatz*(Address) *3314 Fleet St.*

15-

APR 21 1920

ROBERT B. BRAUTER

Filed....., 191.....

Baltimore City Health Department

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

..... 191....., to..... 191.....,

that I saw h..... alive on..... 191.....,

and that death occurred, on the date stated above, at *11:15 P.* m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *L. C. Maramba* M. D.*4/21/20*, 191... (Address) *St. Joseph's Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Sacred Heart Ch.

DATE OF BURIAL,

April 21 1920

20-UNDERTAKER

Lilly and Zile

ADDRESS

403 S. Wolfe St.

important. See instructions on back of certificate.

D42450

HEALTH DEPARTMENT - CITY OF BALTIMORE

D42450

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Marine Hosp.

CITY OF BALTIMORE: (No.

Remington Ave. 31

ST.: 17

WARD)

2-FULL NAME

Stanley S. Walls

(a) RESIDENCE, No.

Bridgeport Corner

(Usual place of abode)

WARD.

Bridgeport Corner

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Mrs. H. Walls

6 DATE OF BIRTH (month, day, and year)

1882

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

38

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

Volunteer Water

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town) (State or country)

Maine

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Marine Hosp. Baltimore

15

APR 21 1920

ROBERT E. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 18 1920

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 19 1920, to April 18 1920

that I last saw him alive on April 17 1920

and that death occurred, on the date stated above, at 3.20 A.M.

The CAUSE OF DEATH* was as follows:

Syphilitic Encephalitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

Broncho pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? no Date of...

Was there an autopsy?

Yes

What test confirmed diagnosis?

post-mortem

(Signed)

Chas. M. Mager

M. D.

19 (Address)

Marine Hosp. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn

Apr 21 1920

20 UNDERTAKER

ADDRESS

Chesapeake & Son

CAUTION is very important. See instructions on back of certificates.

042451

HEALTH DEPARTMENT—CITY OF BALTIMORE

042451

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST.: *W* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary Timmy*

(a) RESIDENCE. NO. *728 S. Hurkum St.* WARD. *12th*

(Usual place of abode)

(If nonresident give city or town and state)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Child*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Child*

6 DATE OF BIRTH (month, day, and year) *Oct. 15 1919*

7 AGE Years *6* Months *6* Days *6* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*
(b) General nature of industry, business, or establishment in which employed (or employer) *000*
(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md* (State or country)

10 NAME OF FATHER *Jacob Timmy*

11 BIRTHPLACE OF FATHER (city or town) *Russia* (State or country)

12 MAIDEN NAME OF MOTHER *Pontine Twarda*

13 BIRTHPLACE OF MOTHER (city or town) *Russia* (State or country)

14 Informant *Hospital Record* (Address)

15 *APR 21 1920* *ROBERT B. KAUTER* Registrar *Bureau Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 21 1920*

17 I HEREBY CERTIFY, That I attended deceased from *April 21 1920* to *April 21 1920*, that I last saw her alive on *April 21 1920*, and that death occurred, on the date stated above, at *11:30 a. m.*

The CAUSE OF DEATH* was as follows:
Meningococcus meningitis

(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary) *none* (duration) yrs. mos. ds.

18 Where was disease contracted *Patent Home* if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Sputal fluid +* (Signed) *J. H. B.* M. D.

4/21 1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Rosary *Apr 21 1920*

20 UNDERTAKER, ADDRESS

Wm. Hallows 168 Eastern Ave

TUTION is very important. See instructions on back of certificates.

D42452 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

120 D42452
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 E Lombard ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2005 E Lombard St. 30 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
married

6-DATE OF BIRTH,

Oct. 18.

(Month)

(Day)

1852

(Year)

7-AGE,

6.7

yrs.

6

mos.

2

ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House Keeping

9-BIRTHPLACE,
(State or Country).

Dames Quarter Somerset Md

10-NAME OF FATHER,

John Rogers

11-BIRTHPLACE OF FATHER
(State or Country).

unknown

12-MAIDEN NAME OF MOTHER

Miranda Shores

13-BIRTHPLACE OF MOTHER
(State or Country).

Dames Quarter Somerset Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Harry White

(Address)

2005 E. Lombard St.

APR 21 1920

ROBERT E. ERAUTER

Filed.....

191

DEPT. OF HEALTH
REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April

20

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

March

1919

to

April 20

1920

that I saw her alive on April 17 1920,

and that death occurred, on the date stated above, at 3.30 Am.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs., mos., ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs., mos., ds.

(Signed)

Ralph A. Hoyt

M. D.

262 Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Olivet Cemetery

DATE OF BURIAL,

Apr 22, 1920

20-UNDERTAKER

H. E. Hughes

ADDRESS

17 S Broadway

important. See instructions on back of certificate.

D42453

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Ambulance: in transit, between

CITY OF BALTIMORE: (No.

R.R. Station & Md. Gen. Hospital

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs. Florence Rebecca Nebel

(a) RESIDENCE. No.

Port Deposit Md.

ST.

WARD.

Port Deposit Md.

(Usual place of abode)

Port Deposit Md.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of (or) wife of

Mr. Geo. F. Nebel

6 DATE OF BIRTH (month, day, and year)

July 30, 1887

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

32.

00

21.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Port Deposit Md.

10 NAME OF FATHER

Geo. Nebel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Port Deposit Md.

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Margaret Archibald

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Port Deposit Md.

14

Informant (Address)

Geo F Nebel (husband), Port Deposit Md.

APR 21 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21 1920

17

I HEREBY CERTIFY, That I attended deceased from Apr 19 1920, to Apr 21 1920, that I last saw her alive on Apr 21 1920, and that death occurred, on the date stated above, at 10 AM.

The CAUSE OF DEATH was as follows:

Ruptured appendix

(duration) yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary)

Peritonitis

(duration) yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death?

Port Deposit Md.

Did an operation precede death?

Yes Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Distended abdomen, & high fever.

(Signed)

W. P. Perry

M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

Port Deposit Md.

20 UNDERTAKER

Harry H. Nisley

DATE OF BURIAL

April 23 1920

ADDRESS

1531 W. Lombard St.

D42451

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42451

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3103 Oakfield Ave ST. 13 WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 ~~Married~~, Widowed,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

APR 21 1920

Robert P. Hall, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-20 1920

17

I HEREBY CERTIFY, That I attended deceased from
April 6, 1920, to April 20, 1920,
that I last saw him alive on April 20, 1920,
and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Infectious Hepatitis(duration) 5 yrs. 5 mos. 5 ds.CONTRIBUTORY
(Secondary)(duration) 4 yrs. 4 mos. 4 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of NoWas there an autopsy? NoWhat test confirmed diagnosis? Winn's(Signed) Winn's M. D.. 19 (Address) 27 31 Parkwood Ave*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Piermont CemeteryApr 23 1920

20 UNDERTAKER

Winn's 17237 Winn's

D42455

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42455

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: Union Ave. Georgetown Rd. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 28 1919

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Joseph B Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Augusta R Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Augusta R Myers
Union Ave. Georgetown Rd.
Robert F. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 20 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 19 1920, to April 20 1920,

that I last saw him alive on April 20 1920,

and that death occurred, on the date stated above, at 11 20 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. Hall M. D.

, 19 (Address) Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Eastern Cemetery April 22 1920

20 UNDERTAKER

ADDRESS

J. M. Cook 502 S. Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

APR 21 1920

Burial Permit Clerk

Registrar

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42456

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2845 W. Lafayette* ST.; *46* WARD)

2-FULL NAME

(Residence in Baltimore: No. *2845 W. Lafayette* St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married*
(Write the word.)

6-DATE OF BIRTH, *December 13, 1876*
(Month) (Day) (Year)

7-AGE, *43* yrs. *5* mos. *7* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Inspector*
(b) General nature of industry, business, or establishment in which employed (or employer), *086*

9-BIRTHPLACE, (State or Country), *Baltimore, Md*

10-NAME OF FATHER, *Robert W. Cather*

11-BIRTHPLACE OF FATHER (State or Country), *Md*

12-MAIDEN NAME OF MOTHER, *Sarah Jacob*

13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Mrs. Annie Cather*(Address), *2845 W. Lafayette*

15-

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 20, 1920*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *April 6, 1920*, to *April 20, 1920*, that I saw him alive on *April 20, 1920*, and that death occurred, on the date stated above, at *3 P. m.*

The CAUSE OF DEATH* was as follows:

Haemophilia secondary to carcinoma lung & abdomen
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Edema of Lung*
(Duration) yrs. mos. ds.

(Signed) *John S. Ireland*, M. D.
April 20, 1920 (Address) *1219 Capital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Western Ave**Apr. 21, 1920*

20-UNDERTAKER

ADDRESS

*Wincroft**1028 North*

important. See instructions on back of certificate.

APR 21 1920

D42457

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D42457

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

ST.:

WARD.

Length of residence in city or town where death occurred 39 yrs.

mos.

How long in U. S., if of foreign birth? 53 yrs. 1 mos. 13 ds

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

John M. D. Andrews

6 DATE OF BIRTH (month, day, and year) March 7th 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
53	1	13		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington Co. Md.

(State or country)

10 NAME OF FATHER George A Warner

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Foutz

13 BIRTHPLACE OF MOTHER (city or town) Washington Co. Md.

(State or country)

14 Informant John M. D. Andrews

(Address)

612 E 34th St

APR 21 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 - 19 20

17

I HEREBY CERTIFY, That I attended deceased from

March 28, 19 20, to April 20, 19 20.

that I last saw him alive on April 20, 19 20.

and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia - pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY Infect. Endocarditis.

(Secondary)

(duration) yrs. mos. 20 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual for Hemip. & Inf.

(Signed) Irving Miller M. D.

4/24, 19 20 (Address) 108 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery

April 23 19 20

20 UNDERTAKER

ADDRESS

George Schilling & Sons

1126 E. Monument

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42458

CERTIFICATE OF DEATH.

151 ✓ D42458
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1407 Lennon ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Moses Mackey

(Residence in Baltimore: No. _____ St.; _____ yrs., _____ mos., _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

Colored3-SINGLE, single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

April 20, 1920
(Month) (Day) (Year)

7-AGE,

_____ yrs. _____ mos. _____ ds.

If LESS than 1 day,
2 hrs. or 15 min.

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country)Maryland

10-NAME OF FATHER,

Moses Mackey11-BIRTHPLACE OF FATHER
(State or Country),Maryland

12-MAIDEN NAME OF MOTHER

Isabel Mitchell13-BIRTHPLACE OF MOTHER
(State or Country),Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) _____

(Address) 1407 Lennon St.

15-

Robert P. Harrison,Barial Permit Clerk

1713K

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 20, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 20 1920, to April 20 1920, that I saw him alive on April 20 1920, and that death occurred, on the date stated above, at 1.15 p.m.
The CAUSE OF DEATH* was as follows:Priestnaturity

(Duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) R. C. Delis M. D.April 20, 1920 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

JOHNS HOPKINS HOSPITAL

_____, 191...

20-UNDERTAKER

ADDRESS

Commissioner Health,APR 2, 1920

Per. Wm. E. WOODALL.

important. See instructions on back of certificate.

D42459

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42459

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1237 E. Madison ST.
CITY OF BALTIMORE: (No. 1237 E. Madison ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Lawrence Webb

(a) RESIDENCE. NO. 1237 E. Madison ST. 10 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. One ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 3 yrs. Years Months Days If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

Robert P. Harrison,
Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1920

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1920, to April 20, 1920, that I last saw him alive on April 20, 1920, and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth
6 1/2 month uterine gestation

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) A. W. McDonald, M. D.

, 12 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITAL

20 UNDERTAKER

Commissioner Health,

ADDRESS

APR 20 1920

Wm. E. Woodall

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

APR 21 1920

Burial Permit Clerk

D42460

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42460

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *13* WARD)

2-FULL NAME

Liberto Altomare(a) RESIDENCE. NO. *46 E. Cross St.*ST. *13* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *13* yrs. mos. ds.How long in U. S., if of foreign birth? *13* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

W.

4 COLOR OR RACE

*White*5 Single, Married, Widowed,
or Divorced (write the word)*Married*5a If married, widowed, or divorced
HUSBAND of
(or WIFE of)*Rose Altomare*

6 DATE OF BIRTH (month, day, and year)

Dec. 18, 1899

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*29**4**2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Barber 004*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Italy*

10 NAME OF FATHER

*Bruno Altomare*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Italy*

12 MAIDEN NAME OF MOTHER

*Rose Corduci*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Italy*

14

Informant
(Address)*Joe. Altomare
220 E. Cross St.*

15

Robert P. Harrison,

Registrar

APR 21 1920

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/20 1920

17

I HEREBY CERTIFY, That I attended deceased from

4/19 1920 to *4/20 1920*that I last saw him alive on *4/20 1920*and that death occurred, on the date stated above, at *3.10 p.m.*

The CAUSE OF DEATH* was as follows:

Mania(duration) *8 mos.* yrs. mos. ds.CONTRIBUTORY
(Secondary)(duration) *6 mos.* yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *Yes* Date of *4/19/20*Was there an autopsy? *No*What test confirmed diagnosis? *Chemical findings*(Signed) *H. Stein* M. D.*4/20 1920* (Address) *University Hospital**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cathedral Cemetery**April 23 1920*

20 UNDERTAKER

W. J. Flynn

ADDRESS

1422 Light

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42461

CERTIFICATE OF DEATH.

REGISTERED NO. 104 ✓

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 N. Luzerne ave ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 106 N. Luzerne ave ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 27 ds.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. 47 ds.

yrs. mos. 47 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 24, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto, Md.

10 NAME OF FATHER

Bernard Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Elizabeth Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

14

Informant (Address)

Bernard Byrne
106 N. Luzerne St.

15

Robert P. Harrison,
Registrar

APR 21 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-21 1920

17

I HEREBY CERTIFY, That I attended deceased from April 19, 1920, to April 19, 1920, that I last saw her alive on April 19, 1920, and that death occurred, on the date stated above, at 4-21 m. The CAUSE OF DEATH was as follows:

Dysentery

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Theodor E. Brown

M. D.

19 (Address)

4046 Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Ceme

April 22 1920

20 UNDERTAKER

M. G. Flynn

ADDRESS

1422 Light

HEALTH DEPARTMENT—CITY OF BALTIMORE

012462

REGISTERED NO

CITY OF BALTIMORE: (No. 370 H. H. H. H. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 3103 4 Vincent ST., 1 WARD.

(Usual place of abode) 57 (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. Now long in U. S., if of foreign birth? 57 yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
-------	-----------------	---

16 DATE OF DEATH (month, day, and year) 4/19/2015 19

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of *widowed of*
William Scott

17 I HEREBY CERTIFY, That I attended deceased from
Apr 16, 19 *20*, to *April 19*, 19 *20*.
 that I last saw h. *v* alive on *Apr 19*, 19 *20*.
 and that death occurred, on the date stated above, at *5 P* m.

6 DATE OF BIRTH (month, day, and year)					8	1863
7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.		
	137	-	5			

The CAUSE OF DEATH* was as follows:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) 18 alttumar
(State or country)

10 NAME OF FATHER *Reed Johnson*

11 BIRTHPLACE OF FATHER (city or town) Bella
(State or country) Canada

12 MAIDEN NAME OF MOTHER *Wanda B. Jones*

13 BIRTHPLACE OF MOTHER (city or town) *Waltham*
(State or country) *Massachusetts*

14 Informant Basil W. Wicks
(Address) 523 N. Lincoln St.

15 Robert P. Harrison,

Cerebral hemorrhage.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY *Arterio-Sclerosis.*

(Secondary)

(duration) 3 yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?.....

What test confirmed diagnosis?

7/20 (Signed) Edmund J. Sweet, M. D.
1920 (Address) 1707 Edmonson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

[illegible]

20 UNDERTAKER ADDRESS 1140

APR 21 1920

~~Partial Permit Clerk~~

D42463

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1726 E Chase

ST.:

WARD)

2-FULL NAME

John H Keichlen

(a) RESIDENCE. No.

1726 Chase

ST.:

WARD.

Hanover Pa.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

WIFE of

Mary Ann Keichlen

6 DATE OF BIRTH (month, day, and year)

1844

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

76

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Post master 186

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

Government

9 BIRTHPLACE (city or town)
(State or country)

Baltimore City

10 NAME OF FATHER

Francis Keichlen

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Europe

12 MAIDEN NAME OF MOTHER

Mary Mass

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Europe

14

Informant
(Address)Charles Keichlen
1726 Chase St

Robert P. Harrison,

Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

X 81

D42463

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr 6, 1920, to Apr 20, 1920,

that I last saw him alive on Apr 20, 1920,

and that death occurred, on the date stated above, at 7:45 P. M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Walter W. White Jr. M. D.

. 19

(Address)

2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hanover, Pa.

April 22, 1920

20 UNDERTAKER

ADDRESS

Robt J Turner: 1442 1/2 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

APR 21 1920

D42461

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42461

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 North Greene

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice A. Powell

(a) RESIDENCE. No. 315 North Greene

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Dr. Samuel F. Powell

6 DATE OF BIRTH (month, day, and year) Jan. 14 1849

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

71

4

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

At home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Not known
(State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known
(State or country)14 Informant Elinor V. Watson
(Address) 2120 W. Lexington St.

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 20th 1920

17

I HEREBY CERTIFY, That I attended deceased from
Apr. 10th, 1920, to Apr. 20th, 1920,that I last saw her alive on Apr. 20th, 1920,

and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

CONTRIBUTORY (Secondary) Old age. duration) yrs. mos. 9 ds.

(duration) yrs. mon. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.
(Signed) J. B. K. M. D.

19 (Address) 1203 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

MOUNT OLIVET.

APR 22 1920

20 UNDERTAKER

ADDRESS

JOHN F. DENNY

715 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be understood by the public. See instructions on back of certificates.

APR 21 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42465

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Protestant ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Simon Wiener(Residence in Baltimore: No. 217 S. Eden St. St. 16 yrs. 16 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married
(Write the word.)

6-DATE OF BIRTH. September, 1854
(Month) (Day) (Year)

7-AGE. 65 yrs. 8 mos. 16 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. 000
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Russia

10-NAME OF FATHER, Morris Wiener

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Solda Schulerman

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 E. Baltimore St.

15- APR 22 1920 ROBERT B. KAUFER
Filed 191 Baltimore Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April, 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 14, 1920, to April 21, 1920, that I saw him alive on April 21, 1920, and that death occurred, on the date stated above, at 10:20 A.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(Duration) 6 yrs. 6 mos. 16 ds.

CONTRIBUTORY Lobar pneumonia
(Secondary)

(Duration) 1 yr. 1 mos. 1 ds.

(Signed) Walter H. H. H. H. M. D.

April 21, 1920 (Address) Union Protestant

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs. 7 mos. 16 ds. In the State 16 yrs. 16 mos. 16 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 217 S. Eden St.

19-PLACE OF BURIAL OR REMOVAL, Heaven

DATE OF BURIAL, 4-22-1920

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E. Baltimore St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST.;WARD) *7*2-FULL NAME *Herbert Davis*(a) RESIDENCE. NO. *1613 Millman St.*

(Usual place of abode)

WARD. *12th*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2 yrs.* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*Colored*5 Single, Married, Widowed,
or Divorced (write the word)*Child*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Child*6 DATE OF BIRTH (month, day, and year) *Dec 26-1912*

7 AGE

7 Years*3* Months*25* DaysIf LESS than
1 day. hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*None*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.*
(State or country)10 NAME OF FATHER *John W Davis*11 BIRTHPLACE OF FATHER (city or town) *Md.*
(State or country)12 MAIDEN NAME OF MOTHER *Addie Dockins*13 BIRTHPLACE OF MOTHER (city or town) *Md.*
(State or country)

14

Informant *Hospital Record*
(Address) *J. H. H.*

15

Noted

APR 22 1920

ROBERT E. KRAUTER
Registrar

Burial Permit Office

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 20 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*April 2, 1920, to April 20, 1920.*that I last saw him alive on *April 20, 1920.*and that death occurred, on the date stated above, at *2:55* a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis(duration) yrs. *1* mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted *Patent home*
if not at place of death?Did an operation precede death? *No* Date of *—*Was there an autopsy? *Yes*What test confirmed diagnosis? *Autopsy*(Signed) *W. H. H.*

, M. D.

, 19 (Address) *1111**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laurel

DATE OF BURIAL

April 23 1920

20 UNDERTAKER

*John W Henderson*ADDRESS *1502**E. M. M. M.*CAUSE OF DEATH in plain terms, so that it may be properly entered
TION is very important. See instructions on back of certificates.

D42468

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D42468
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3512 Reland ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 3512 Reland ave St.; 30 yrs., 1 mos., 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

M

4-COLOR OR RACE,

W.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH,

April 2 no, 1861
(Month) (Day) (Year)

7-AGE,

59 yrs., 19 mos., 19 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business, or establishment in which

employed (or employer).

Mill Hand
086

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

Christopher Cunningham

11-BIRTHPLACE OF FATHER (State or Country),

Don't Know

12-MAIDEN NAME OF MOTHER

Mary Taylor

13-BIRTHPLACE OF MOTHER (State or Country),

Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Emma Cunningham
3512 Reland ave

15-

APR 22 1920

ROBERT H. ELLAUTE

Filed

191

G. F. Evans & Son
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 19 1920, to April 19 1920.that I saw him alive on April 19 1920,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Pneumonia Tuberculosis

.....

.....

..... (Duration) 3 yrs., 1 mos., 1 ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) 3 yrs., 1 mos., 1 ds.(Signed) A. J. Daines M. D.4 21, 1920 (Address) 800 W. 33rd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

St. Mary's in Hampden

20-UNDERTAKER

Chas. F. Evans & Son 116 W. 1st Ave

DATE OF BURIAL

4 23, 1920

ADDRESS

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. 75* WARD)

2-FULL NAME

Bud Brower

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

(Usual place of abode)

Fairfield P.O. Balt.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Widowed

6 DATE OF BIRTH (month, day, and year)

June 10-1885

7 AGE

Years

Months

Days

34 10 9

If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labourer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Alabama

10 NAME OF FATHER

Thos. Brower

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N. C.

12 MAIDEN NAME OF MOTHER

Jane Shumberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N. C.

14

Informant (Address)

Hospital Record

15

Filed

APR 22 1920

ROBERT E. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 19 1920

17

I HEREBY CERTIFY, That I attended deceased from

*March 29, 1920, to April 18, 1920.*that I last saw him alive on *April 19, 1920.*and that death occurred, on the date stated above, at *10:45 p. m.*

The CAUSE OF DEATH* was as follows:

Generalized tuberculosis(duration) *1* yrs. *1* mos. *0* ds.

CONTRIBUTORY (Secondary)

(duration) *—* yrs. *—* mos. *—* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Wm. B. Pendergast*, M. D., 19 (Address) *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Central Church**Apr 22 1920*

20 UNDERTAKER

ADDRESS

Charles F. Pendergast

CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter statement on back of certificates. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D4247E

CERTIFICATE OF DEATH.

120 D4247E

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 N. Hoffman ST.; 11 WARD)

REGISTERED No. C

2-FULL NAME

Catherine Powell

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 410 N. Hoffman St.; 20 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow6-DATE OF BIRTH, Ukron, 1870
(Month) (Day) (Year)7-AGE, 50 yrs., mos., ds. If LESS than 1 day, hrs. or min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housework
(b) General nature of industry, business, or establishment in which employed (or employer), at home9-BIRTHPLACE, (State or Country), Ta.10-NAME OF FATHER, Ukron11-BIRTHPLACE OF FATHER (State or Country), Ukron12-MAIDEN NAME OF MOTHER, Catherine Anderson13-BIRTHPLACE OF MOTHER (State or Country), Ta.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar Powell(Address) 410 N. Hoffman St.15- APR 22 1920 ROBERT B. KAUTERFiled 191Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April, 19, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Jan 25, 1920, to April 19, 1920, that I saw him alive on April 19, 1920, and that death occurred, on the date stated above, at 9:45 a.m.The CAUSE OF DEATH* was as follows:
Subacute nephritis(Duration) 4 yrs., mos., ds.CONTRIBUTORY Valvular disease of heart(Duration) 2 yrs., mos., ds.(Signed) J. D. Lightfoot M. D.4/19, 1920 (Address) 211 N. Tawman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.Where was disease contracted, if not at place of death? Former or usual residence 19-PLACE OF BURIAL OR REMOVAL, St. Lukes CemeteryDATE OF BURIAL, Apr 22 192020-UNDERTAKER, Edward J. HenderADDRESS, 387 E. Pratt

CAUSE OF DEATH IN plain terms, so that it may be properly important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE **D42472****D42472**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. **2337 Sticker** ST.: **19** WARD) **77**2-FULL NAME **Elizabeth C Taylor**(a) RESIDENCE. No. **2337 Sticker** ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **36** yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Female**4 COLOR OR RACE **White**5 Single, Married, Widowed, or Divorced (write the word) **Widowed**5a If married, widowed, or divorced HUSBAND of (or) WIFE of **Dr. Wm. C. Taylor**6 DATE OF BIRTH (month, day, and year) **Nov 19-1878**

7 AGE

Years **74**Months **5**Days **1**

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work **Housewife**(b) General nature of industry, business, or establishment in which employed (or employer) **wife**(c) Name of employer **own home**9 BIRTHPLACE (city or town) **Baltimore** (State or country) **Md.**10 NAME OF FATHER **Burlington Carlisle**11 BIRTHPLACE OF FATHER (city or town) **Baltimore** (State or country) **County Md.**12 MAIDEN NAME OF MOTHER **Ann Gill**13 BIRTHPLACE OF MOTHER (city or town) **Baltimore** (State or country) **County Md.**

14

Informant **Albert C. Taylor** (Address) **433 Rosedale Ave**

15

Filed **APR 22 1920****ROBERT S. BRADLEY****Burial Permit**

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **Apr 20 1920**

17

I HEREBY CERTIFY, That I attended deceased from **Apr 19**, 19 **20**, to **Apr 20**, 19 **20**, that I last saw her alive on **Apr 20**, 19 **20**, and that death occurred, on the date stated above, at **7:45 P. M.**

The CAUSE OF DEATH* was as follows:

Acute myocardial infarction super-induced by an old pericarditis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) **Arterio-sclerosis**(duration) **5** yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) **Bernard French** M. D.19, 19 (Address) **1707 Edmond Ave**

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park**April 23 1920**

20 UNDERTAKER

ADDRESS

George Smith**1000 W. Gay St.**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42473

CERTIFICATE OF DEATH.

79 D42473
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5194, Arlington Ave. ST. 18 WARD)

2-FULL NAME

(Residence in Baltimore: No. 5194, Arlington Ave. St.; 80 yrs., 12 mos. 12 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F4-COLOR OR RACE, W.5-SINGLE, single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

April 8, 1880
(Month) (Day) (Year)

7-AGE,

80 yrs. 12 mos. 12 ds.

If LESS than 1 day,

....hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country), Baltimore Md.10-NAME OF FATHER, James Nelson11-BIRTHPLACE OF FATHER
(State or Country), Md.12-MAIDEN NAME OF MOTHER, Mary Ely Fair13-BIRTHPLACE OF MOTHER
(State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

APR 22 1920 ROBERT B. KAUTER

Filed..... 191. 8-24-14 10:15 AM
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan. 1 1919, to Apr. 20 1920,that I saw h alive on Apr. 20 1920,and that death occurred, on the date stated above, at 7:50 a.m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Infarction, Cardiac Hypertrophy, Interstitial Nephritis, Arteriosclerosis..... (Duration) 4 yrs. 12 mos. 12 ds.CONTRIBUTORY
(Secondary) Arteriosclerosis..... (Duration) 4 yrs. 12 mos. 12 ds.(Signed) J. H. Pharo M. D.4/21, 1920 (Address) 804 Calver St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

April 23, 1920

20-UNDERTAKER

George J. Smith

ADDRESS

1012 E. 1st St.

CAUSE OF DEATH in plain terms, so that it may be properly entered important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42471

CERTIFICATE OF DEATH.

120

D42471

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

34. Cor Fulton Ave and Franklin St.

WARD)

2-FULL NAME

Susan R. Burgess

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

Home for the Aged of the U. E. Church

St.; 71 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Mch

31

1849

(Month)

(Day)

(Year)

7-AGE,

71

0

20

ds.

If LESS than 1 day,

✓ hrs. or ✓ min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Retired

(b) General nature of industry, business, or establishment in which employed (or employer).

Palis lady

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

10-NAME OF FATHER,

Caleb Burgess.

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland.

12-MAIDEN NAME OF MOTHER

Elizabeth Smith.

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Records of Methodist Home

(Address)

Fulton & Franklin St.

15-

APR 22 1920

ROBERT E. KAUTER

Baptist Church

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr.

21

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mch 4

1920

to Apr 21

1920

that I saw her alive on

Apr 20

1920

and that death occurred, on the date stated above, at 5¹⁵ a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration)

3 yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Arterio Sclerosis

(Duration)

6 yrs.

mos.

ds.

(Signed)

George C. Shannon M. D.

4/21, 1920

(Address)

700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

8 yrs.

mos.

ds.

In the State

71 yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Greenmount

Apr 23, 1920

20-UNDERTAKER

ADDRESS

George Smith

700 Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42475

D42475

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2214 Eager Place ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2214 Eager Place St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single
(Write the word.)

6-DATE OF BIRTH, Feb 7, 1920
(Month) (Day) (Year)

7-AGE, 2 yrs., 13 mos., 13 ds. If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, none
(b) General nature of industry, business, or establishment in which employed (or employer), none

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, Harro Hildebrand

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Ethel P. Bright

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ethel P. Bright

(Address) 2214 Eager Place

15-APR 22 1920 ROBERT K. KRAUTER
Filed..... 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 18 1920, to April 23 1920, that I saw her alive on April 20 1920, and that death occurred, on the date stated above, at 1015 P. m. The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Signed) Chas. B. Fischer M. D.
April 21, 1920 (Address) 830 W. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

St. Malheur Cemetery April 23, 1920
20-UNDERTAKER Henry Lutz ADDRESS 1007 N. Bond

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42476

CERTIFICATE OF DEATH.

D42476

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1210 N. Charles*ST. *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Emma J. Greene*(a) RESIDENCE. NO. *1210 N. Charles*ST. *11* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 ~~Single~~ Married, Widowed, or Divorced (write the word) *Widow*

5a If married, widowed, or divorced

~~HUSBAND~~ of
(or) WIFE of*Benson M. Greene*6 DATE OF BIRTH (month, day, and year) *Mar 12, 1843*7 AGE Years *77* Months *1* Days *8* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lady at

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore Md.*10 NAME OF FATHER *James M. Lester*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Balto. Md.*12 MAIDEN NAME OF MOTHER *Elizabeth Reese*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Balto. Md.*14 Informant *Mrs. Lloyd L. Jackson*
(Address) *1210 N. Charles St.*15 *APR 22 1920* *ROBERT E. KRAUTER*
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 20th 1920*

17

I HEREBY CERTIFY, That I attended deceased from *April 1st 1920*, to *April 20th 1920*,that I last saw h. ex. alive on *April 20th 1920*,and that death occurred, on the date stated above, at *5* a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis(duration) *2* yrs. mos. ds.CONTRIBUTORY
(Secondary)*Debility of Old Age*

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Thomas L. Shearer*, M. D.*Apr. 22, 1920* (Address) *905 N. Charles St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Landon Park

DATE OF BURIAL

4-23-1920

20 UNDERTAKER

Henry W. Jenkins & Sons Co

ADDRESS

McClulloh Orchard

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *4* WARD)2-FULL NAME *George Harmon*(a) RESIDENCE. NO. *771 N Saratoga* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1 1/2* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *colored* 5 Single, Married, Widowed, or Divorced (write the word) *married*5a If married, widowed, or divorced HUSBAND of *unknown* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *Dec 25, 1889*7 AGE Years *60* Months *3* Days *26* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Barber*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *Geo. Robinson Dennis*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Mary Harmon*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland*14 Informant *Hospital Record* (Address) *H. H.*15 Filed *APR 22 1920*

ROBERT R. KRAUTER

Burial *1811 0107*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 20* 19 *20*17 I HEREBY CERTIFY, That I attended deceased from *April 5*, 19 *20*, to *April 20*, 19 *20*, that I last saw him alive on *April 20*, 19 *20*, and that death occurred, on the date stated above, at *5-10 P.* m.

The CAUSE OF DEATH* was as follows:

Curious of liver(duration) *?* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) *4* yrs. mos. ds.18 Where was disease contracted *in* if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *yes*(Signed) *Robert R. Krauter* M. D.19 (Address) *J. H. Corp*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS *916*

Information should be carefully supplied. Exact statement in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. *3026 Walbrook Ave*)

FULL NAME

Mrs Virginia Hollett

(Residence in Baltimore: No. *3026 Walbrook Ave*)

REGISTERED NO. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *45* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

White

SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(If write the word)

Widow

DATE OF BIRTH

Sept. 14th, 1836
(Month) (Day) (Year)

AGE

83 yrs. *7* mos. *5* ds. or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

At home

BIRTHPLACE

(State or country)

West Virginia

NAME OF FATHER

Henry Miller

BIRTHPLACE OF FATHER

(State or country)

West Virginia

MAIDEN NAME OF MOTHER

Ann Brown

BIRTHPLACE OF MOTHER

(State or country)

West Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bessie Hollett

(Address)

3026 Walbrook Ave

15.

APR 22 1920

ROBERT F. ERAUTER

Burial & Registration

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

April 19, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

April 19, 1920, to *April 19*, 1920.

that I saw her alive on *April 19*, 1920.

and that death occurred, on the date stated above, at *10:40 P. M.*

The CAUSE OF DEATH* was as follows:

*Cerebral Hemorrhage
with Paralysis*

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)

Cardiac Asthenia

(Duration) yrs. mos. ds.

(Signed), *Herbert E. Giff* M. D.

April 21, 1920. (Address) *3050 N. North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Mary's Cemetery

April 22, 1920

UNDERTAKER

ADDRESS

Horace Currier & Son 3631 Falls Rd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42479

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 Hawthorne Rd. ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Milton Mitchell

(a) RESIDENCE. NO.

2315 N. CharlesST. 12 WARD. (Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 5 mos. 26 ds. How long in U. S., if of foreign birth? 60 yrs. 5 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

Mollie A. Mitchell6 DATE OF BIRTH (month, day, and year) October 25-1859

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.60526

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Secretary

(b) General nature of industry, business, or establishment in which employed (or employer)

W.H. Tomlin Mfg.

(c) Name of employer

Company9 BIRTHPLACE (city or town)
(State or country)Baltimore
Maryland

10 NAME OF FATHER

John T. Mitchell

11 BIRTHPLACE OF FATHER (city or town)

Fredrick
Maryland

(State or country)

12 MAIDEN NAME OF MOTHER

Miss Newton

13 BIRTHPLACE OF MOTHER (city or town)

not known
not known

(State or country)

14

Informant
(Address)Mr. J. Calvin Mitchell - (son)
201 Hawthorne Road

15

Filed

APR 22 1920ROBERT A. EASTER
RegistrarBurial Permit Grant

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 13th, 1920, to April 20th, 1920,that I last saw him alive on April 20th, 1920,and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(duration) yrs. 8 mos. 8 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? noWhat test confirmed diagnosis? Physical Exam. & course of(Signed) Edmund R. Clarke M. D., 19 (Address) Roland Park - Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Wellfleet CemeteryApr 22 1920

20 UNDERTAKER

STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

Cause of death should be carefully reported. Exact statement of cause of death is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42480

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-STATUS *Widow*
(Write the word.)

6-DATE OF BIRTH,

2

(Month)

(Day)

(Year)

7-AGE,

*91**2**18*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

APR 22 1920 191..... ROBERT A. KRANTZ
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*4**22**1920*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from *April 22* 191 to *April 22* 191

that I saw h *Ev* alive on *April 22* 191, and that death occurred, on the date stated above, at *1:30* a.m.

The CAUSE OF DEATH* was as follows:

Infirmities of
Old Age
(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Injury due to
Falls from a height
(Duration) yrs. mos. ds.
22 191 (Address) *1314 Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

*Baltimore**April 24 1920*

20-UNDERTAKER

ADDRESS

*Fiskler Fiskler**Eager*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42481

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42481

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *University Hospital* ST. *14* WARD)

2-FULL NAME *John H. Terrell*

(Residence in Baltimore: No. *2110 D Hill an*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *40* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Jan 2, 1887
(Month) (Day) (Year)

7-AGE,

43 yrs. 3 mos. 18 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Merchant*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), *Va.*

10-NAME OF FATHER, *Spencer Terrell*

11-BIRTHPLACE OF FATHER (State or Country), *Va.*

12-MAIDEN NAME OF MOTHER *Louise Marick*

13-BIRTHPLACE OF MOTHER (State or Country), *Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant *Mary H. Terrell*

(Address *2190 Lemay Hill*

15-

APR 22 1920

ROBERT R. ELAUTE

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 20, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry) find that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound in brain

(Duration) yrs. mos. ds. *a few hrs.*

CONTRIBUTORY (Secondary) *shot by Mary Terrell*

(Duration) yrs. mos. ds. *a few hrs.*

(Signed) *H. R. Garrison* M. D.

41.22. 19120 (Address) *11.2. in Saratoga St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Harrisonburg Va

Apr 24 1920

20-UNDERTAKER

ADDRESS

George H. Holland

631 Lemay Hill

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42482

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *15* ST. *15* WARD)

FULL NAME

(Residence in Baltimore: No. *3634 Park Heights Ave.* St.: yrs., mos. *21* ds.)

REGISTERED NO. *C*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

Aug 14, *1898*
(Month) (Day) (Year)

7-AGE,

21 yrs. *8* mos. *7* ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Auditor

(b) General nature of industry, business, or establishment in which employed (or employer).

Standard Oil

9-BIRTHPLACE,
(State or Country).

Brooklyn, N.Y.

10-NAME OF FATHER,

Thos. F. Dixon

11-BIRTHPLACE OF FATHER
(State or Country),

Brooklyn

12-MAIDEN NAME OF MOTHER

Mabel E. Adams

13-BIRTHPLACE OF MOTHER
(State or Country),

Brooklyn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

LeRoy Tilt

(Address)

1018 N. Charles

APR 22 1920

ROBERT B. LEAUBER

Filed

101

Regist.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr 21, *1920*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Struck by a street railway car.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Fracture of skull

(Signed) *F. E. Smith* M. D.

(Coroner.)

4/27/20 (Address) *1018 N. Charles*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

Brooklyn, N.Y.

19-PLACE OF BURIAL OR REMOVAL,

Brooklyn, N.Y.

DATE OF BURIAL,

April 25, *1920*

20-UNDERTAKER,

Jirkler & Jirkler

ADDRESS

1739 Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42483

D42483

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1741 Light St.

ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Mary Mentis

(Residence in Baltimore: No. 1741 Light

St. yrs. 7 mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH Aug. 22, 1919 (Month) (Day) (Year)

7-AGE yrs. 7 mos. 30 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Balto., Md.

10-NAME OF FATHER George Mentis

11-BIRTHPLACE OF FATHER (State or country) Greece

12-MAIDEN NAME OF MOTHER Stamatina Magoulas

13-BIRTHPLACE OF MOTHER (State or country) Greece

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Mentis (Father)

(Address) 1741 Light St.

15

APR 22 1920

ROBERT A. FRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Apr. 21, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 17, 1920, to Apr. 21, 1920, that I saw her alive on Apr. 21, 1920, and that death occurred, on the date stated above, at 3 P. m. The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) yrs. 7 mos. 7 ds. Contributory Acute dilatation heart (SECONDARY)

(Signed) U. P. Tumbleson M. D. Apr. 21, 1920 (Address) 2013 Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted. If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Woodlawn Cem. DATE OF BURIAL April 22, 1920

20-UNDERTAKER M. H. Flynn ADDRESS 1422 Light

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42481

CERTIFICATE OF DEATH.

D42481

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2211 St. PaulST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Myra Laura White(a) RESIDENCE. NO. Salisbury Md

(Usual place of abode)

ST., — WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

30 yrs. — mos. — ds.

How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 24 1843

7 AGE

Years

Months

Days

77228

If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Barnes Co. Ind.
(State or country)

10 NAME OF FATHER

James White11 BIRTHPLACE OF FATHER (city or town)
(State or country)Maryland

12 MAIDEN NAME OF MOTHER

Adaline White13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Maryland

14

Informant
(Address)Mr. J. S. Sullivan

15

APR 22 1920ROBERT E. KAUFER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1920

17

I HEREBY CERTIFY, That I attended deceased from March 24 1920 to April 22 1920, that I last saw her alive on April 20 1920, and that death occurred, on the date stated above, at 5:50 a.m.
The CAUSE OF DEATH* was as follows:Angina Pectoris
Remote cause not known
(duration) 4 yrs. — mos. — ds.CONTRIBUTORY
(Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed)

C. H. Hampton, M. D.
, 19 (Address) 2514 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Salisbury Md.

DATE OF BURIAL

4/22/20 19

20 UNDERTAKER

H. W. Jenkins & Sons Co. M^{rs} Callahan

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42485

CERTIFICATE OF DEATH.

79

D42485

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725 Light.

ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary A. Miller

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

68 yrs. 1 mos. 9 ds.

How long in U. S., if of foreign birth?

68 yrs. 1 mos. 9 ds.

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John A. Miller

6 DATE OF BIRTH (month, day, and year)

Mar 11-1852

7 AGE

68

1

9

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

John. Vogel.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant Mrs. M. P. aff. (Address) 1723 Light.

15

APR 22 1920

ROBERT A. KAUFER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/20 1920

17

HEREBY CERTIFY, That I attended deceased from June 24, 1919, to April 21, 1920, that I last saw her alive on April 15, 1920.

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Cardiac Arrhythmia

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 ds. Semicerebral (duration) yrs. 9 mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy.

(Signed) J. J. Humphreys M. D.

4/22/1920 (Address) 160 Russell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Cem

DATE OF BURIAL

4/23 1920

20 UNDERTAKER

J. F. M. Gully

ADDRESS

130 E. Fort.

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificates.

D42487

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42487

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) *Md. General Hospital*ST.: *2* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Margaret Kirsch

(a) RESIDENCE. No

2003 Eastern Ave

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Robert Kirsch

6 DATE OF BIRTH (month, day, and year)

April 29, 1852

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

George Hoy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Christiana Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Henry Pfeiffer 326 S. Robinson

APR 22 1920

Robert F. Harrison, Jr. Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 20 1920*

17

I HEREBY CERTIFY, That I attended deceased from *April 19*, 1920, to *April 30*, 1920, that I last saw her alive on *April 20*, 1920, and that death occurred, on the date stated above, at *7:20 P.* m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis with hypertension

CONTRIBUTORY (Secondary)

several (duration) yrs. mos. ds.*Cerebral hemorrhage*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

2003 Eastern Ave.

Did an operation precede death?

no Date of

Was there an autopsy?

no

What test confirmed diagnosis?

urinalysis(Signed) *H. E. Wright*

M. D.

4/20, 1920 (Address)

Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Matthews**April 24 1920*

20 UNDERTAKER

William Cook

ADDRESS

582 S. North Ave

D42488

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42488

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3000 Barclay St. ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Zollinhofer(a) RESIDENCE. NO. 3000 Barclay
(Usual place of abode)ST. 17 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced
HUSBAND of Frederick Zollinhofer
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Mar 7 18437 AGE 77 Years Months Days 1 14
If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. city
(State or country)10 NAME OF FATHER Wm. Keys11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., md.12 MAIDEN NAME OF MOTHER Eveline Lawton13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Cincinnati

14

Informant
(Address)James G. Harrison
Robert P. Harrison
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 192817 I HEREBY CERTIFY, That I attended deceased from Nov 1 1919 to April 21 1920,
that I last saw her alive on April 20 1920,
and that death occurred, on the date stated above, at 1:15 a. m.
The CAUSE OF DEATH* was as follows:Chronic Interstitial Nephritis(duration) 5 yrs. 21 mos. 21 ds.CONTRIBUTORY
(Secondary)(duration) 5 yrs. 21 mos. 21 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis Urinary. Gran Carls + C
(Signed) August Horn, M. D.19 (Address) 40 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London ParkApril 24 1928

20 UNDERTAKER

ADDRESS

William Cook502 S. North
Ave

Information should be carefully supplied. AGE should be given in years, months, and days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 1/2 Woodley St. ST.; 16 WARD)2-FULL NAME Martha A. Garzide(a) RESIDENCE. NO. 10 1/2 Woodley ST., 16 WARD.

(Usual place of abode)

(If nonresident give city or town and State)
Length of residence in city or town where death occurred 4 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 4 yrs. 0 mos. 0 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofJames Garzide6 DATE OF BIRTH (month, day, and year) Dec 26/18537 AGE Years 66 Months 3 Days 26 If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)10 NAME OF FATHER Joseph Taylor11 BIRTHPLACE OF FATHER (city or town) MD.
(State or country)12 MAIDEN NAME OF MOTHER Frances Famburn13 BIRTHPLACE OF MOTHER (city or town) MD.
(State or country)

14

Informant
(Address)Wm E. Garzide
10 1/2 Woodley St.Robert F. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2/192017 I HEREBY CERTIFY, That I attended deceased from March 15, 1920, to date of death, that I last saw him alive on April 2, 1920, and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:Intestinal neoplasia(duration) Indefinite yrs. — mos. — ds.CONTRIBUTORY
(Secondary)(duration) — yrs. — mos. — ds.18 Where was disease contracted
If not at place of death?Did an operation precede death? — Date of —Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Plasden R. Davis, M. D., 19 (Address) 827 N. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Landen ParkApril 4/1920

20 UNDERTAKER

ADDRESS

Wm Crick143 N. E. Ave.

nation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

APR 22 1920

D42490

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42490

CERTIFICATE OF DEATH.

X 32

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *John Hopkins Hosp* ST.: *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Pearl Stevens*(a) RESIDENCE. NO. *Fairmount W. Va.* ST. *W.D.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. *5*

mos.

ds.

How long in U. S., if of foreign birth? *4/1* yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Divorced*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of *John Stevens*6 DATE OF BIRTH (month, day, and year) *Unknown 1892*

7 AGE

Years *38*Months *—*Days *—*If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *at home*(c) Name of employer *Fairmount W. Va.*

9 BIRTHPLACE (city or town)

(State or country) *Fairmount W. Va.*10 NAME OF FATHER *John Morgan*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *W. Va.*12 MAIDEN NAME OF MOTHER *Adeline*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *W. Va.*

14

Informant *John*
(Address) *1411 E. B. Ave.*

15

Robert P. Harrison,

Registrar

APR 22 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 21* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from *Jan. 24* 19 *20* to *April 21* 19 *20*.that I last saw her alive on *April 21* 19 *20*.and that death occurred, on the date stated above, at *10:15 P. m.*

The CAUSE OF DEATH* was as follows:

Tuberculosis of Spine(duration) *1* yrs. mos. ds.CONTRIBUTORY *abscess infected*
(Secondary)(duration) *1* yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *W. Va.*Did an operation precede death? *yes* Date of *3-15-20*Was there an autopsy? *no*What test confirmed diagnosis? *Exam.*(Signed) *Allen D. O'Neill*, M. D.4/21, 1920 (Address) *John Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Fairmount W. Va.

DATE OF BURIAL

4-27-20

20 UNDERTAKER

Jack Lewis

ADDRESS

1411 E. B. Ave.

mation should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42491

HEALTH DEPARTMENT—CITY OF BALTIMORE

152 D42491

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1005 W. Fayette St. 19

2-FULL NAME

(Residence in Baltimore: No. 1005 W. Fayette St.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Apr. 18, 1920
(Month) (Day) (Year)

7-AGE,

Yrs. mos. ds.

1/2 LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert F. Harrison,

Bureau Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr. 18, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart failure
as a result of coronary
disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. E. Smith, M. D.

4/21/20 (Address) 910 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Commissioner Health,

W. E. WOODALL

D42492

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42492

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 EdwardST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Perry Gibson(a) RESIDENCE. NO. 1226 Edward

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs.

mos.

ds. How long in U. S., if of foreign birth? 62 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male colored married

5a If married, widowed, or divorced

(or) WIFE of

Eliza Gibson

6 DATE OF BIRTH (month, day, and year)

unknown 1858

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

62 yrs. — mos. — ds.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

F. H. Gibson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

md

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

md

14

Informant (Address)

Eliza Gibson
12206 Edward St

15

Robert P. Harrison,

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 1920

17

I HEREBY CERTIFY, That I attended deceased from Feb 4, 1920, to Apr 19, 1920, that I last saw him alive on April 19, 1920, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Septicemia

CONTRIBUTORY (Secondary)

Infected Jaw Bone
(duration) yrs. 3 mos. ds.

18 Where was disease contracted if got at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Fisher, M. D.
4-21-20 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Asbury CemeteryApr 23 1920

20 UNDERTAKER

ADDRESS

Mrs R. A. Elliott

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

042493

REGISTERED NO. C

CITY OF BALTIMORE: (NO.

ST. 1 WARD)

2-FULL NAME

(Residence in Baltimore: No.

St. 20 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

MEDICAL CERTIFICATE OF DEATH.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

OF BIRTH, unknown, 1880
(Month) (Day) (Year)

7-AGE.

40 yrs. — mos. — da.

It LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE
OF FATHER
(State or Country).

12-MAIDEN NAME
OF MOTHER

**13-BIRTHPLACE
OF MOTHER
(State or Country).**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)...

15-

Robert P. Harrison

121

Registrar.

16-DATE OF DEATH,

16-DATE OF DEATH, 4 20, 1920
.....
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from
Apr. 7 1920, to Apr. 20 1920,
that I saw her alive on Apr. 20 1920,
and that death occurred, on the date stated above, at 10 p.m.

The CAUSE OF DEATH* was as follows:

Varicella of the
heart

CONTRIBUTORY
(Secondary)

(Secondary) (Duration) yrs. mos. d.
(Signed) *P. G. and Christine* M. I.
Apr 22, 1980 (Address) *1534 S. Al*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted,
if not at place of death?.....

Former or
usual residence

10-PLACE OF BURIAL OR REMOVAL,

20-UNDERTAKER

DATE OF BURIAL,

Apr. 23., 1925

ADDRESS 725

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42491

HEALTH DEPARTMENT-CITY OF BALTIMORE

D42491

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

3505 Starr Lane

ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

John C. Henneman

(Residence in Baltimore: No.

3505 Starr Lane

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Jan

6th, 1914

7 AGE

6

yrs.

3

mos.

16

ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE (State or country)

Baltimore

PARENTS

10 NAME OF FATHER

John C. Henneman

11 BIRTHPLACE OF FATHER (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Cornelia Elder

13 BIRTHPLACE OF MOTHER (State or country)

Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John C. Henneman

(Address)

3505 Starr Lane

Robert P. Harrison,

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Apr 22

1940

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Apr 20, 191, to, Apr 21, 1920.

that I saw him alive on Apr 21, 1920.

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Scarlet fever

(Duration) yrs. mos. 3 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) H. P. Stittgen Jr. M. D.

Apr 22, 1920 (Address) 632 Yarrow Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Western Cem.

DATE OF BURIAL

Apr 23, 1920

20 UNDERTAKER

H. Scherman Son

ADDRESS

1034

APR 22 1920

D42495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42495

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

St. Agnes' Hospital

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Mr. Harry C. Bell Jr.

(a) RESIDENCE. NO.

803 Edmonson Ave

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

27 yrs.

7 mos.

7 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 9 1892

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

27 yrs

9

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Fairbanks Scale Co.

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Harry C. Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Alice A. Hollins

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Mr. Harry C. Bell Jr. 803 Edmonson Ave

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 20 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 15, 1920, to Apr. 20, 1920

that I last saw him live on Apr. 20, 1920

and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

Acute Cardiac Distention

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 86 3 Edmonson Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings & clinical

(Signed) Damian A. O'Leary M.D.

19 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cem

Apr 23 1920

20 UNDERTAKER

Joseph B. Cook

ADDRESS

103 N. Bell St.

APR 22 1920

Burial Permit Clerk.

Information should be carefully supplied. Cause of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1448 Montpelier ST.; 39 WARD)

REGISTERED NO. C. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1448 Montpelier St.; 40 yrs., _____ mos., _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE. <u>White</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <u>Married</u>
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6-DATE OF BIRTH. <u>November 20, 1868</u> (Month) (Day) (Year)	7-AGE. <u>50</u> yrs., <u>5</u> mos., _____ ds. If LESS than 1 day, _____ hrs. or _____ min.
--	--

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).	<u>Housewife</u> <u>037</u>
--	--------------------------------

9-BIRTHPLACE, (State or Country), <u>Ill.</u>

10-NAME OF FATHER, <u>Mrs. Philip</u>	11-BIRTHPLACE OF FATHER (State or Country), <u>Ill.</u>
12-MAIDEN NAME OF MOTHER, <u>Mary A. Thompson</u>	13-BIRTHPLACE OF MOTHER (State or Country), <u>Ill.</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James C. Bay
(Address) 1448 Montpelier St.

15- Filed <u>APR 23 1920</u>	<u>ROBERT S. KRAUTER</u> Borial Permit Clerk
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MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, <u>April 28, 1920</u> (Month) (Day) (Year)
--

17- I HEREBY CERTIFY, That I attended deceased from April 28, 1920, to April 28, 1920, that I saw her alive on April 20, 1920, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus
.....
..... (Duration) yrs. 6 mos. ds.

CONTRIBUTORY.....
(Secondary).....
(Signed) John H. ... D.
Apr. 21, 1920 (Address) 401 E. 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? _____
Former or usual residence _____

19-PLACE OF BURIAL OR REMOVAL, <u>St. Johns Cemetery</u>	DATE OF BURIAL, <u>April 23, 1920</u>
20-UNDERTAKER, <u>Geo. Lumbach & Co.</u>	ADDRESS, <u>647 W. Pratt St.</u>

N.B.—Every item of information should be carefully checked. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42497

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42497

PLACE OF DEATH

CITY OF BALTIMORE (NO. *Franklin Sq. Hosp.* 17 WARD)2-FULL NAME *Charles A. Kemner*(Residence in Baltimore: No. *535 W. Biddle St.*)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: *Life* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *Colored* 5-SINGLE, *Married*, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, *Aug 3, 1896*
(Month) (Day) (Year)7-AGE, *23* yrs. *8* mos. *16* ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Chauffeur*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Balto md*10-NAME OF FATHER, *Henry H. Kemner*11-BIRTHPLACE OF FATHER (State or Country), *md*12-MAIDEN NAME OF MOTHER *Mary Green*13-BIRTHPLACE OF MOTHER (State or Country), *va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Estelle Kemner*(Address) *535 W. Biddle St.*

15-APR 23 1920 Burial Permit Order

Filed, 191. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Apr 19, 1920*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)hereon and from the evidence obtained by said *inquest* and that said deceased came to *death* (topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Automobile accident

Duration) yrs. mos. ds.

CONTRIBUTORY *Fracture of skull* (Secondary)

Duration) yrs. mos. ds.

(Signed) *P. E. Smith* M. D.4/21, 1920 (Address) *901 E. Mt. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. *4* ds. In the *Life* State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

*Washington Boulevard*Former or usual residence, *535 W. Biddle St.*

19-PLACE OF BURIAL, OR REMOVAL, DATE OF BURIAL,

Mt. Auburn Cemetery *Apr 23, 1920*20-UNDERTAKER ADDRESS *1234**Jas. M. Johnson* *Eding St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

140322
D42498

CERTIFICATE OF DEATH.

92 D42498

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. 25 WARD)2-FULL NAME *John Szczepanski*

(a) RESIDENCE

No. *800**Brookland Heights* ST. *12th*WARD. *12th*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

*Child*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Child*

6 DATE OF BIRTH (month, day, and year)

June 22 1910

7 AGE

9

Years

10

Months

Days

If LESS than
1 day. hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Maryland*

10 NAME OF FATHER

*John Szczepanski*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Poland*

12 MAIDEN NAME OF MOTHER

*Mary Bogomila*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Maryland*

14

Informant
(Address)*Hospital Record*

15

Filed

APR 23 1920

ROBERT B. KRAUTER
Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

25

12th

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 22 1920

17

I HEREBY CERTIFY, That I attended deceased from

*April 19, 1920, to April 22 1920,*that I last saw him alive on *April 22, 1920,*and that death occurred, on the date stated above, at *9:15 a. m.*

The CAUSE OF DEATH* was as follows:

Polar pneumonia(duration) yrs. mos. *13* ds.CONTRIBUTORY
(Secondary)*Empyema*(duration) yrs. mos. *?* ds.18 Where was disease contracted
if not at place of death?*Patent home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *clinical*

(Signed)

Unstapf

, M. D.

21920 (Address)

21st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Cross A. C. Co. Md.**April 24 1920*

20 UNDERTAKER

ADDRESS

William Gielkowski 1618 Eastern Ave.

Spec. 8-24-14 M. & T.—2000 Bks.
N. B. Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec. 8-24-14 M. & T.—2000 Bks.
D42499

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42499

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 732 N. Carrollton ave. ST.; 16 WARD)

2-FULL NAME

(Residence in Baltimore: No. 732 N. Carrollton ave St.; 15 yrs., — mos. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
widowed

6-DATE OF BIRTH

Month 15, 1845
(Month) (Day) (Year)

7-AGE

75 yrs. 1 mos. 7 ds.

If LESS than 1 day,hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Retired

9-BIRTHPLACE, (State or Country),

N. Y.

10-NAME OF FATHER,

David Walker

11-BIRTHPLACE OF FATHER (State or Country),

Boston Mass

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

..

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susie A. Lane

(Address) 732 N. Carrollton ave

15-FILED

APR 23 1920

ROBERT B. KRAUTER

Filed..... 191

BURIAL PERMIT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

April 22, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 10, 1920, to April 22, 1920, that I saw him alive on April 18, 1920, and that death occurred, on the date stated above, at 9:09 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
a few minutes
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Nephritis (Duration) yrs. mos. ds.
(Signed) C. L. ... M. D.

April 23, 1920 (Address) 111 N. Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park, April 24, 1920

20-UNDERTAKER

John Mitchell 1201 N. Fayette

D42500

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42500

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *216 N. Lenoire* ST.; *11* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Margaret A. Jones*(Residence in Baltimore: No. *216 N. Lenoire* St. *16* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)
6-DATE OF BIRTH, *Jan 30, 1847*
(Month) (Day) (Year)
7-AGE, *73* yrs. *22* mos. ds. If LESS than 1 day, hrs. or min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *at home*
(b) General nature of industry, business, or establishment in which employed (or employer). *037*

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

APR 23 1920

ROBERT F. KRAUTER

Butler-Pennell-Clark
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 21, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

*Feb 15, 1920, to April 21, 1920,*that I saw her alive on *April 21, 1920,*

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

*mitral regurgitation
chronic myocarditis*(Duration) *20* yrs. mos. ds.CONTRIBUTORY
(Secondary)(Duration) *4* yrs. mos. ds.(Signed) *Wm. Freeman* M. D.*4/22, 1920* (Address) *412 Patterson St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Landon Park**Apr 24, 1920*

20-UNDERTAKER

ADDRESS

*John C. Mitchell**1301 W. Fayette St.*

N.B.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N.B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH
D42501
County _____

170 ✓
STATE OF MARYLAND
042501
CERTIFICATE OF DEATH

Registration Dist. No. _____

Village or City Baltimore (No. Park & Delaware Aves. St. 26 Ward)
Raspeburg.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John M. Hetzler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED, WIDOWED OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH January 23 1857
(Month) (Day) (Year)

7 AGE 63 yrs. 2 mos. 29 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Book binder
(b) General nature of industry, business, or establishment in which employed (or employer) Printing 064

9 BIRTHPLACE (State or country) Maryland.

PARENTS
10 NAME OF FATHER John Hetzler
11 BIRTHPLACE OF FATHER (State or country) Md.
12 MAIDEN NAME OF MOTHER Martha Adams
13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. M. Hetzler

(Address) Raspeburg, Balt., Md.

15 APR 23 1920 ROBERT R. KAUTER
Filed _____, 191

Burial Permit - 0122

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 22 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from June 1, 1919 to April 22, 1920, that I last saw him alive on April 21, 1920, and that death occurred on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH * was as follows:
Chronic Interstitial Nephritis

Duration probably 10 to 12

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) A. L. Wilkinson
April 22 1920 (Address) Raspeburg, Balt., Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Western Ceme. April 26, 1920

20 UNDERTAKER

ADDRESS 1034

E. Schlomant 1034

D42502

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42502

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Josephs Hospital* ST.: *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Jacob Uhl

(a) RESIDENCE. No.

604 N Kenwood Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 19 1918

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*1**10**2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Jacob Uhl

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Maryland

12 MAIDEN NAME OF MOTHER

Rosina Kratz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Maryland

14

Informant (Address)

Jacob Uhl 604 N. Kenwood Ave

APR 23 1920

ROBERT K. KRATZER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 21 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*April 20 1920, to April 21 1920*that I last saw him alive on *April 21 1920*and that death occurred, on the date stated above, at *9 P* m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism (Conv)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Depressed fracture of skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*at home*Did an operation precede death? *yes* Date of *April 20*Was there an autopsy? *no*What test confirmed diagnosis? *operation*(Signed) *Daniel Miller* M. D.. 19 (Address) *St Josephs Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Prinzing Cemetery April 22 1920

20 UNDERTAKER

ADDRESS

H. Sander Saus 1700 Pratt

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D42503

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42503

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 623 St Annis Ave. ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Edward Smith(a) RESIDENCE. No. 623 St Annis. ST.; 9 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of Sarah or WIFE of William E. & Sarah Smith6 DATE OF BIRTH (month, day, and year) Sept 2-19187 AGE Years 1 Months 9 Days 000 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)10 NAME OF FATHER James B. Smith11 BIRTHPLACE OF FATHER (city or town) Richmond Va (State or country)12 MAIDEN NAME OF MOTHER Sarah M. Duff13 BIRTHPLACE OF MOTHER (city or town) N. Carolina (State or country)14 Informant Sarah W. Smith (Address) 623 St Annis Ave15 Filed APR 23 1920 ROBERT R. KRAUTER RegistrarBurial Permit 0122

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22nd 19 2017 I HEREBY CERTIFY, That I attended deceased from April 20th, 19 20, to April 22nd, 19 20that I last saw him alive on Apr. 22nd, 19 20, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Gonorr. Enteritis(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? HomeDid an operation precede death? No Date of 20Was there an autopsy? NoWhat test confirmed diagnosis? Franklin 0102(Signed) Franklin 0102 M. D.(Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Cross Hayford Rd20 UNDERTAKER William Cook

DATE OF BURIAL

April 23rd

ADDRESS

5026

N. B.—WRITE FULL NAME OF DECEASED IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

151

D42504

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 320 Oakley Road ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 540 Valley Road St.; yrs., mos. ds.)

MEDICAL CERTIFICATE OF DEATH.

3-SEX, *Male* 4-COLOR OR RACE, *W.* 6-SINGLE, ~~MARRIED,~~ WIDOWED, OR DIVORCED, (*Write the word.*)

6-DATE OF BIRTH, April 26, 1920
(Month) (Day) (Year)

7-AGE, yrs. mos. 1 da.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....none
(b) General nature of industry, business, or establishment in which employed (or employer).....food

9-BIRTHPLACE,
(State or Country), *Balto*

10-NAME OF FATHER, *Walter R. Jones*

11-BIRTHPLACE
OF FATHER
(State or Country), *Balto md*

12-MAIDEN NAME
OF MOTHER *Mrs. G. H. ...*

13-BIRTHPLACE
OF MOTHER
(State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*W. D. Nelson*.....

(Address) 320 Oakley Rd.

15- AD 100 1000 ROBERT A. LAUTER

APR 25 1920 Special Agent in Charge

Registrar.

16-DATE OF DEATH, April 22nd 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 21 1920, to Apr. 22 1920, that I saw him alive on Apr. 21 1920, and that death occurred, on the date stated above, at 24 m.

The CAUSE OF DEATH* was as follows:
Premature birth
7 mo. intra-uterine

..... (Duration) yrs. mon. / da.

CONTRIBUTORY.....*unknown*..... Canal of.....
(Secondary)

Pre-mature Labor (Duration).....yrs.....mos.....ds.

(Signed).....*L. C. Mott*..... M. D.

4-22, 1922 (Address) ... 190 B W. North St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted,
if not at place of death?.....

Former or
usual residence _____

10-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
--------------------------------	-----------------

(S)ack Toronto Apr 23 1940

20-UNDERTAKER	ADDRESS
---------------	---------

[illegible]

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42505

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 61 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

APR 23 1920

ROBERT B. BRADY

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 12 1920, to April 20 1920, that I saw her alive on April 20 1920, and that death occurred, on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) August Horn M. D.

April 21, 1920 (Address) 40 E 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42506

CERTIFICATE OF DEATH.

28 D42506

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2117 Wilhelm)ST. 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Roesler(Residence in Baltimore: No. 2117 Wilhelm)St.; 31 yrs., 4 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white5-SINGLE,
MARRIED, married,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

November 28, 1888.
(Month) (Day) (Year)

7-AGE,

31 yrs., 4 mos., 24 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Photographer

9-BIRTHPLACE,

(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Ernest Roesler

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Marie Brownrother

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Roesler(Address) 2117 Wilhelm St.

15-

APR 23 1920

BOLENT R. KAUTER

Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 21, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 1 - 1919, to April 21 1920,that I saw him alive on April 21 1920,and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 2 yrs., 6 mos., — ds.CONTRIBUTORY
(Secondary)(Duration) — yrs., — mos., — ds.(Signed) Chester Roland, M. D.4-21-1920. (Address) 2532 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral Cemetery

DATE OF BURIAL,

April 24, 1920.

20-UNDERTAKER

F. B. Wippert

ADDRESS

2236 Frederick Ave.

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42507

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42507

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 Sharp ST. 23 WARD)2-FULL NAME Nattie Matthews(a) RESIDENCE. NO. 1115 Sharp ST. 23 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Col.

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/10/19

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

512

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

VA.10 NAME OF FATHER Hopper Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country)

VA.12 MAIDEN NAME OF MOTHER Bessie Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

VA.

14

Informant (Address)

Hopper Matthews
1115 Sharp St

15

Filed

APR 23, 1920ROBERT B. TRAUTMANBRIEF Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/22/1920

17

I HEREBY CERTIFY, That I attended deceased from April 19th, 1920, to April 22nd, 1920, that I last saw him alive on April 22nd, 1920.and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis
with Pertussis

CONTRIBUTORY (Secondary)

Cold & Bronchitis

18 Where was disease contracted If not at place of death?

VA.

Did an operation precede death?

no

Was there an autopsy?

clinical

What test confirmed diagnosis?

(Signed)

4/27/20

(Address)

J. Guy Bowley, M. D.
908 S Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Int Auburn StApril 23 1920

20 UNDERTAKER

J. H. Brown & Son

ADDRESS

108 W. Monty

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D42508

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42508

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *108 N. Carlton* ST.; *18* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *108 N. Carlton* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

*Cel*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH,

Unknown, *1* (Month) (Day) (Year)

7-AGE

28 yrs. mos. ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Day Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer) *040*9-BIRTHPLACE, (State or Country), *unknown*

PARENTS.

10-NAME OF FATHER, *unknown*11-BIRTHPLACE OF FATHER (State or Country), *unknown*12-MAIDEN NAME OF MOTHER *unknown*13-BIRTHPLACE OF MOTHER (State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Agnes M. Elif*(Address) *108 N. Carlton St.*

15-

Filed *APR 23 1920*

ROBERT B. KAUFER

Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 22*, 191*1*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 19* 191*1*, to *April 22* 191*1*that I saw him alive on *April 22* 191*1*and that death occurred, on the date stated above, at *6:00* m.

The CAUSE OF DEATH* was as follows:

John P. Freeman
(Duration)yrs.mos.ds. *3*

CONTRIBUTORY (Secondary)

(Signed) *J. P. Stoddard* M. D.
4/22, 191*1* (Address) *11711 Carnegie*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mt Auburn Ct*DATE OF BURIAL, *April 24 1920*

20-UNDERTAKER

ADDRESS

John P. Freeman and Son *108 N. Montg.*

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 10-9-17 H. 17-18-19 1000 Hks.

D42509

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 Wilkens Ave.

ST.:

WARD:

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Menkmeier

(a) RESIDENCE. No. 1607 Wilkens Ave.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Elizabeth T. Menkmeier

6 DATE OF BIRTH (month, day, and year) March 16, 1874

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 46 1 5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Freco Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Benson

9 BIRTHPLACE (city or town) Baltimore, Maryland. (State or country)

10 NAME OF FATHER John Henry Menkmeier

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs. Elizabeth Menkmeier (Address) 1607 Wilkens Ave.

15 APR 23 1920

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1920

17

I HEREBY CERTIFY. That I attended deceased from Jan 20, 1920, to April 21, 1920, that I last saw him alive on April 20, 1920,

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Septicemia

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. Campbell M. D. 22, 1920 (Address) 1644 Hancock St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cem

Apr. 23 1920

20 UNDERTAKER

Joseph B Cook

ADDRESS

1003 N. Balto Street

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42510

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or WIFE of)

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

APR 23 1920

ROBERT E. KRAUTER Registrar
Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21 1920

17

I HEREBY CERTIFY, That I attended deceased from July 9, 1919, to Apr 21, 1920, that I last saw him alive on Apr 20, 1920, and that death occurred, on the date stated above, at 342 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

M. D.

4/21, 1920 (Address) 1319 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42511

CERTIFICATE OF DEATH.

REGISTERED NO. C

D42511

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1942 W. Mulberry ST. 760 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1942 W. Mulberry St.; — yrs., 6 mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widow
(Write the word.)

6-DATE OF BIRTH, Sept 8, 1840
(Month) (Day) (Year)

7-AGE, 79 yrs. 7 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. at home
(b) General nature of industry, business, or establishment in which employed (or employer). Household duties

9-BIRTHPLACE, (State or Country), in united states 37 years
England

10-NAME OF FATHER, Alfred Savory
11-BIRTHPLACE OF FATHER (State or Country), England
12-MAIDEN NAME OF MOTHER Rebecca unknown
13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Ann Scales(Address) 14 Leethrope Md.

APR 23 1920

ROBERT B. FRADY

Filed 191 REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 20, 1919
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1910, to April 20 1919, that I saw h. or alive on April 20 1919, and that death occurred, on the date stated above, at 6:30 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Coronary atherosclerosis
(Duration) 7 yrs. mos. ds.

CONTRIBUTORY Hypertension
(Secondary)

(Duration) 3 yrs. mos. ds.
(Signed) Edwin C. Reuter M. D.
April 21, 1919 (Address) Baltimore Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 6 yrs. mos. ds. In the State 17 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Massachusetts

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery DATE OF BURIAL, April 23, 1919

20-UNDERTAKER, Geo. A. Herbig 2001 W. Baltimore St. ADDRESS

N.B.—Every item of information should be carefully supplied. AGE must be stated in years, months, and days. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42512

D42512

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *5224 Denmore Ave.* ST.; *27* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *5224 Denmore Ave* St.: yrs. mos. *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*Caucasian*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Single* Write the word.)

6-DATE OF BIRTH,

April 20, 1920
(Month) (Day) (Year)

7-AGE,

yrs. mos. *2* ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ada Wilkinson*(Address) *5224 Denmore Ave.*

15-APR 23 1920

Filed *191*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 22, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*April 20, 1920, to April 22, 1920,*that I saw her alive on *April 22, 1920,*

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

*Probably Pneumonia
with failure of
action of Heart Valve*
(Duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. *2* ds.(Signed) *John D. Waller* M. D.191... (Address) *Ashtington*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

At Annapolis

JAMES M. DENNIS

1303 PRESTMAN ST.

N. B.—Every item of information should be carefully supplied. AGE must be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42513

CERTIFICATE OF DEATH.

D42513

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. *5* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Melvin Samunder*(a) RESIDENCE. No. *419 Central Ave* ST. *12th* WARD. *12th*
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Child*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Child*6 DATE OF BIRTH (month, day, and year) *Jan 19-1920*7 AGE Years *3* Months *2* Days If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.* (State or country)10 NAME OF FATHER *Clarence Thompson*11 BIRTHPLACE OF FATHER (city or town) *Md.* (State or country)12 MAIDEN NAME OF MOTHER *Louise Samunder*13 BIRTHPLACE OF MOTHER (city or town) *Md.* (State or country)14 Informant *Hospital Record* (Address) *76 76*15 Filed *APR 23 1920* *ROBERT A. KRAUTER* Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 21 1920*17 I HEREBY CERTIFY, That I attended deceased from *Apr 13*, 1920, to *April 21*, 1920, that I last saw him alive on *April 21*, 1920, and that death occurred, on the date stated above, at *3:15 a.m.* The CAUSE OF DEATH* was as follows:
*Tuberculosis*CONTRIBUTORY *Sepsis* (Secondary) (duration) yrs. mos. *7* ds. (duration) yrs. mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Harold L. Higgins* M. D. *April 22, 1920* (Address) *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Laurel Cemetery *APR 23 1920*
20 UNDERTAKER *R. C. Frost / 1405 McElderry St* ADDRESS

N. B.—WRITE PLAINLY, WITH CARE. INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42514

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Balt. Gen. Hospital 24* ST. WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *South Balt. Gen. Hosp.* St.; yrs., mos. *7* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

September 10, 1856.
(Month) (Day) (Year)

7-AGE,

63 yrs. *7* mos. *13* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Housewife*

9-BIRTHPLACE, (State or Country),

Pennsylvania

10-NAME OF FATHER,

John Hyson

11-BIRTHPLACE OF FATHER (State or Country),

Pennsylvania

12-MAIDEN NAME OF MOTHER

Margaret Miller

13-BIRTHPLACE OF MOTHER (State or Country),

Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lemona Breneman*(Address) *South Balt. Gen. Hospital*15-*APR 23 1920*

Filed.....

ROBERT B. KRAUTH
Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 23, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *4-16-20* 1920, to *4/23/20* 1920, that I saw her alive on *4/23/20* 1920 and that death occurred, on the date stated above, at *6:30 P.M.*

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY *Myocardial Insufficiency*
(Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) *Wellsboro Fort* M. D.*4/23/20, 1920.* (Address) *1213 Eight St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *7* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Stewartstown Pa.*

19-PLACE OF BURIAL OR REMOVAL,

Stewartstown Pa.

DATE OF BURIAL,

April 24 1920

20-UNDERTAKER

M. G. Flynn

ADDRESS

1422 Light

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42515

CERTIFICATE OF DEATH.

REGISTERED NO. C

D42515

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 Madison ST.; 244 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1625 Madison St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)6-DATE OF BIRTH, Sept 22, 1882 (Month) (Day) (Year)7-AGE, 37 yrs., 6 mos., 30 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, None (b) General nature of industry, business, or establishment in which employed (or employer), 0379-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, William N. Bolander11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Bolander(Address) 1625 Madison15-APR 23 1920 ROBERT B. ERAUTER
Filed..... 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 21, 1920 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 7 1917, to April 21 1920, that I saw her alive on April 21 1920, and that death occurred, on the date stated above, at 3 a m. The CAUSE OF DEATH* was as follows:Acute Dilatation of heart(Duration)..... yrs..... mos..... ds. few yrsCONTRIBUTORY (Secondary) Lobar Pneumonia(Duration)..... yrs..... mos..... ds. 2 wks(Signed) Dr. J. H. D. April 23, 1920 (Address) 1124 20th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery DATE OF BURIAL, April 24, 192020-UNDERTAKER, Henry S. Morris & Son ADDRESS 805 N. Calvert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. This statement of OCCUPATION is important. See instructions on back of certificate.

N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42516

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42516

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 414 E. 22 St

St.: 12 WARD

REGISTERED No. C

2-FULL NAME

Nathaniel Watts

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 414 - E. 22 St.

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Mr.

4-COLOR OR RACE

W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Married (Write the word.)

6-DATE OF BIRTH

Aug 23, 1883 (Month) (Day) (Year)

7-AGE

36 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

Retiree

9-BIRTHPLACE

(State or Country)

Balt Co

10-NAME OF FATHER

B. Watts

11-BIRTHPLACE OF FATHER

(State or Country)

Balt Co

12-MAIDEN NAME OF MOTHER

Rachel Wagner

13-BIRTHPLACE OF MOTHER

(State or Country)

Balt Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Nathaniel Watts
414 E. 22 St

15-

Marital Permit Clerk

APR 23 1920

101

DEPT. OF HEALTH

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

April 22, 1920 (Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

inquest, and

thereon and from the evidence obtained by said

(Inquest)

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary disease of heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Harrison M. D. (Coroner.)

June 20, 1920 (Address) 7632 Roland St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL

DATE OF BURIAL

Stone Chapel

April 24, 1920

20-UNDERTAKER

ADDRESS

E. A. Wiedefeld

101

D42517

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes' Hospital* WARD)2-FULL NAME *Mr. Eugene Burton*(a) RESIDENCE. NO. *608 St. Balto St.* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *12* yrs. mos. ds.(If death occurred in a hospital or institution, give its NAME instead of street and number.)
(If nonresident give city or town and State)
How long in U. S., if of foreign birth? *12* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 COLOR OR RACE *Wh.*5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Apr 15 1886*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*34**?**?*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Attorney*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) *Ind*10 NAME OF FATHER *John Burton*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Balto Md*12 MAIDEN NAME OF MOTHER *John / Mary*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Balto Md*

14

Informant
(Address) *Mrs. Mary Calhoun*

15

File

Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 22 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*April 6, 1920, to April 22, 1920*that I last saw him alive on *April 22, 1920*and that death occurred, on the date stated above, at *6:45 P* m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis(duration) yrs. *6* mos. ds.CONTRIBUTORY
(Secondary) *Nephritis*(duration) yrs. mos. *2*18 Where was disease contracted
if not at place of death? *Home*Did an operation precede death? *No* Date of *✓*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Frank V. Lee*, 19 (Address) *St. Agnes**State the Disease Causing Death
state (1) Means and Nature of
Suicidal, or Homicidal. (See re)

19 PLACE OF BURIAL, CREM

20 UNDERTAKER

Robert

APR 23 1920

Burial Permit Clerk.

N. B.—WRITE PLAINLY, and state EXACTLY. The statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. The statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D42518

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42518

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Med. General Hospital

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Samuel S. Flood

(a) RESIDENCE. No.

637 W. Schroeder

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

71 yrs. 8 mos.

ds.

How long in U. S., if of foreign birth?

71 yrs. 8 mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Elizabeth A. Flood

6 DATE OF BIRTH (month, day, and year)

Aug. 20, 1848

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

71

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

Wash. D. C.

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md

10 NAME OF FATHER

Thomas G. Flood

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mary A. Robins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

London Eng.

14

Informant
(Address)Elizabeth A. Flood
637 W. Schroeder St.

15

File

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/22 1920

17

I HEREBY CERTIFY, That I attended deceased from

3/25

1920, to

4/22

1920.

that I last saw him alive on

4/22

1920.

and that death occurred, on the date stated above, at 11:25 P.m.

The CAUSE OF DEATH* was as follows:

(1) Hypertrophied Prostate with
(2) Acute Retention of Urine

(duration) 1 1/2 yrs. 2 mos. ds.

CONTRIBUTORY
(Secondary)

Acute Cordis Dilatation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted
if not at place of death?

Home

Did an operation precede death?

Yes

Date of

4/22/20

Was there an autopsy?

No

What test confirmed diagnosis?

Operation & Physical Exam.

(Signed)

William B. Dutton

M. D.

Address

4221 1920 Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Md. General Hospital

Apr. 26, 1920

20 UNDERTAKER

George J. Smith

ADDRESS

1000 W. Fayette

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

APR 23 1920

D42519

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42519

CERTIFICATE OF DEATH.

(PLACE OF DEATH

CITY OF BALTIMORE (No. 2010 W. Hollins St.

St.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Bonsall

(Residence in Baltimore: No. 2010 W. Hollins St.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
	White	Single
DATE OF BIRTH.		
About Apr. 14, 1920		
(Month) (Day) (Year)		
AGE.		
About 1 yrs. or less than 1 day, 1 hrs. or less than 1 day, 1 mos. or less than 1 day, 1 ds.		

6-OCCUPATION:

- (a) Trade, profession, or particular kind of work. Non
- (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto. Md.

10-NAME OF FATHER.	Unknown
11-BIRTHPLACE OF FATHER (State or Country).	Unknown
12-MAIDEN NAME OF MOTHER	Anna M. Bonsall
13-BIRTHPLACE OF MOTHER (State or Country).	Maryland

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Bonsall

(Address) 2010 W. Hollins St.

15-

Filed 3-18-20

191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr. 14, 1920 191

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said. (Inquest, au-

Inquiry. And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Baby found in a trunk supposed to have been put there by the mother who is dead. Probably suffocation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Edw. Smith M. D.

(Coroner)

Address 191

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

HOPKINS HOSPITAL

191

20-UNDERTAKER

Commissioner Health.

ADDRESS

APR 13 1920

D42520

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42520

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: Municipal Tuberculosis Hospital ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Bryant

(a) RESIDENCE. NO. 303 N. Green St. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854
7 AGE Years Months Days If LESS than 1 day, hrs. or min.
66

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Edge gilder 086
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Boston (State or country) Mass.

10 NAME OF FATHER Michael Bryant
11 BIRTHPLACE OF FATHER (city or town) (State or country) Newfoundland
12 MAIDEN NAME OF MOTHER Marie Devereaux
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Newfoundland

14 Informant Hospital Records JOHNS HOPKINS HOSPITAL (Address) N.T.H.

15 Filed Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 1920

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1920, to April 21, 1920, that I last saw him alive on April 21, 1920, and that death occurred, on the date stated above, at 10.25 a.m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
(duration) Unknown yrs. mos. ds.
CONTRIBUTORY Tuberculous laryngitis (Secondary) (duration) Unknown yrs. mos. ds.

18 Where was disease contracted Unknown
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum.

(Signed) Guy R. Wilkinson, M.D.

4-21-20 Address Municipal Tuberculosis Ho

*State the Disease Causing Death, or in deaths from Violent Cause state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF HOPKINS HOSPITAL

20 UNDERTAKER ADDRESS Commissioner of Health, APR

Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

APR 23 1920

British Consul Clerk

Wm E. WOODALL

D42521

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42521

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1339 James St

ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Mary Wiesner

(a) RESIDENCE. No. 1339 James St

ST., 21 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 7 mos.

ds. How long in U. S., if of foreign birth?

yrs. 7 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 1919

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md
(State or country)

10 NAME OF FATHER

Karl Wiesner

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Austria

12 MAIDEN NAME OF MOTHER Catherine Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Balto, Md.

14

Informant
(Address)

Karl Wiesner

1339 James St

15

By

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-22 1920

17

I HEREBY CERTIFY, That I attended deceased from
April 8, 1920, to April 22, 1920.

that I last saw her alive on April 22 1920, 19

and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

(duration) 1 yrs. 1 mos. 1 ds.

CONTRIBUTORY
(Secondary)

Exhaustion

(duration) yrs. 3 mos. 3 ds.

18 Where was disease contracted
if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

[Signature]

M. D.

4.23.20 (Address) 517 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

April 24 1920

20 UNDERTAKER

ADDRESS

Wendell O'Connell & Son

378 Ave

APR 23 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42522

CERTIFICATE OF DEATH.

79✓ D42522

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Jo. College* ST.: *25* WARD)

2-FULL NAME

(a) RESIDENCE. No. *25 St. Jo. College* ST.: *25* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *5* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth *life* yrs. *0* mos. *0* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *no*6 DATE OF BIRTH (month, day, and year) *Sept 7-1901*7 AGE Years *18* Months *7* Days *6* If LESS than 1 day, hrs. *—* or min. *—*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Student*(b) General nature of industry, business, or establishment in which employed (or employer) *no*

(c) Name of employer

9 BIRTHPLACE (city or town) *Moss* (State or country)10 NAME OF FATHER *John Mueby*11 BIRTHPLACE OF FATHER (city or town) *Moss* (State or country)12 MAIDEN NAME OF MOTHER *Catherine Mueby*13 BIRTHPLACE OF MOTHER (city or town) *Moss* (State or country)

14

Informant (Address) *Rev. John Mueby*

15

Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 21* 19*20*17 I HEREBY CERTIFY, That I attended deceased from *March 1*, 19*20*, to *Apr 21*, 19*20*;that I last saw him alive on *April 21*, 19*20*,and that death occurred, on the date stated above, at *7P* m.

The CAUSE OF DEATH* was as follows:

*Myocardial Insufficiency*CONTRIBUTORY (Secondary) *Influenza (1918)* (duration) *1* yrs. *0* mos. *0* ds.18 Where was disease contracted *New Port News* if not at place of death?Did an operation precede death? *no* Date of *no*Was there an autopsy? *no*What test confirmed diagnosis? *micro*(Signed) *W. A. Mueby*, M. D.1920 (Address) *Long St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral Cem.**April 24* 19*20*

20 UNDERTAKER

ADDRESS

*F. A. Frame & Son**163 Hammond*

APR 23 1920

Burial Permit Clerk.

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D42523

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42523

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: *625 N. Bradford St.*

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. *625 N. Bradford St.*

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *life* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*Col.*5-SINGLE,
MARRIED,
WIDOWED
OR DIVORCED.
(Write the word.) *Married*

6-DATE OF BIRTH,

July 10, 1870
(Month) (Day) (Year)

7-AGE,

50 yrs. *9* mos. *11* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer) *170*9-BIRTHPLACE,
(State or Country),*Balt Co. Md*

10-NAME OF FATHER,

*Wm Mansfield*11-BIRTHPLACE OF FATHER
(State or Country),*Balt Co Md*

12-MAIDEN NAME OF MOTHER

*Maria Perry*13-BIRTHPLACE OF MOTHER
(State or Country),*Balt Co Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Amis Kesteven*(Address) *625 N. Bradford St.*

15-

Robert P. Harrison,

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 22, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

Sept 17, 1919, to *22/4/20*, 19*20*,that I saw him alive on *21/4/20*, 19*20*and that death occurred, on the date stated above, at *6:00 a.m.*

The CAUSE OF DEATH was as follows:

Chronic Interstitial Nephritis & Starvation
etc. etc.

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *E. Mansfield* M. D.*22/4/20* (Address) *625 N. Bradford St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Sharp Street Cemetery, Bengies, Md. *25 1920*

20-UNDERTAKER

ADDRESS

Milton Davis, 413 N. Eden St.

N.B.—Every item of information should be carefully supplied. Accuracy of information is important. See instructions on back of certificate.

APR 23 1920

D42524

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42524

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 & Ann)

2-FULL NAME

Leonard Schaldach(a) RESIDENCE. NO. 413 & Ann

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 7 mos. 18 ds.

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Helen Schaldach

6 DATE OF BIRTH (month, day, and year)

Sept 4, 1857

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

62718

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cooper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Conrad Schaldach

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margaret Herold

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Helen Schaldach
413 & AnnRobert P. Harrison,

Registrar

APR 23 1920

Burial Permit Clerk.

ST.:

WARD)

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? life yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-22 19 20

17 I HEREBY CERTIFY, That I attended deceased from

March - 19 18, to April 22 - 19 20that I last saw him alive on April 21 19 20and that death occurred, on the date stated above, at 1130 Q

The CAUSE OF DEATH* was as follows:

Valvular Coriary Dis + Arterial
Sclerosis

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.Gravine & heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. P. Harrison M. D.19 (Address) 125 S. Bk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

W. C. Carmel Cem

20 UNDERTAKER

John Ulbrich

DATE OF BURIAL

April 24 19 20

ADDRESS

2008 Dulaney

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE CAREFULLY CLASSIFIED. EXACT STATEMENT OF CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. See instructions on back of certificates.

D42525

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1004*)ST.: *48*WARD: *25*

2-FULL NAME

Mollie Vallet(a) RESIDENCE. No. *1004*

(Usual place of abode)

WARD.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *life* yrs.

mos.

ds.

How long in U. S., if of foreign birth *life* yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)*Married*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Oct 9th 1882*

7 AGE

Years

Months

Days

If LESS than
1 day..... hrs.
or..... min.*37**5**13*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Housewife*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore**md*

10 NAME OF FATHER

*G. H. Frahtman*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Germany*

12 MAIDEN NAME OF MOTHER

*Elizabeth Klingman*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Balto*

14

Informant
(Address)*Adolph J. Vallet**1004 W. Pratt St*

Robert P. Harrison,

19

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-22-1920*

17

I HEREBY CERTIFY, That I attended deceased from
April 18, 19*20*, to *April 22*, 19*20*,
that I last saw him alive on *April 22*, 19*20*,
and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Peritonitis(duration) yrs. mos. *3* ds.CONTRIBUTORY
Secondary*due to a fall from steps*
(duration) yrs. mos. *4* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis

(Signed) *Stephen A. Drain*, M. D.19 (Address) *1227 Columbia Ave**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Graceton Park**April 26 1920*

20 UNDERTAKER

ADDRESS

John Fields 1200 W. Lombard

APR 23 1920

N. B.—WRITE CAREFULLY. Information should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

*I think after talking with Dr. Drain this certificate is correct.**J. J. Jones*
Coroner, Md.

D42526

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42526

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 S. Clinton ST.; 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Louisa Schroeter(a) RESIDENCE. No. 201 S. Clinton ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE ofE. L. Schroeter

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 61 Months 4 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1920

17

I HEREBY CERTIFY, That I attended deceased from Jan 4, 1920, to April 21, 1920, that I last saw her alive on April 21, 1920.and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Synergy fully attack of Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

M. D.

(Address) 3048 10th Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

BaltimoreApril 24 1920

20 UNDERTAKER

ADDRESS

Geo W Little531 St

N. B.—WRITE PLAINLY, WITH CLARITY. AGE should be stated. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

APR 23 1920

Burial Permit Clerk.

D42527

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42527

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amos Wright(Residence in Baltimore: No. 1623 W. North Ave. St.; 38 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

1864 Dec, 28, 1864
(Month) (Day) (Year)

7-AGE,

563 yrs., 25 mos., — ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Collector(b) General nature of industry, business, or establishment in which employed (or employer). Unknown 072

9-BIRTHPLACE, (State or Country),

Harve de Grace, Md.

PARENTS.

10-NAME OF FATHER,

John Wright

11-BIRTHPLACE OF FATHER (State or Country),

Harford Co., Md.

12-MAIDEN NAME OF MOTHER

Martha J. Fawcett
Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Cecil Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Records(Address) New City Hospital

15-

Robert P. Harrison,191Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 23, 1920, 191...
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 12, 19120, to April 23, 19120, that I saw him alive on April 22, 19120, and that death occurred, on the date stated above, at 5:10 m.

The CAUSE OF DEATH* was as follows:

A.M.Carcinoma of Esophagus
Unknown
(Duration) — yrs., — mos., — ds.

CONTRIBUTORY (Secondary)

Toxemia
(Duration) — yrs., — mos., — ds.(Signed) Frank T. Barber M. D.April 23, 19120 Address New City Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

April 26, 1920

20-UNDERTAKER

Geo W Little

ADDRESS

531 N. Fremont

N.B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

APR 23 1920

D42528

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42528

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *765 W. Pratt* ST. *21* WARD)

2-FULL NAME

Henry B. Hughes

(a) RESIDENCE. No.

765 W. Pratt

ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *71* yrs. mos. ds. How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

*Ellen Hughes*6 DATE OF BIRTH (month, day, and year) *Mar. 14-1849*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
71- 1 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Stationary Engineer

9 BIRTHPLACE (city or town) (State or country)

Balto.

10 NAME OF FATHER

William Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind.

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind.

14

Informant (Address)

Ellen Hughes
*765 W. Pratt St.**Robert F. Harrison,*

Registrar

Barrel Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 20 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*April 16 1920 to April 20 1920*that I last saw him alive on *April 20 1920*and that death occurred, on the date stated above, at *9 P* m.

The CAUSE OF DEATH* was as follows:

*Chronic Intestinal
Nephritis with Hypertension
& uremia & Convulsion*(duration) *1* yrs. *6* mos. *6* ds.

CONTRIBUTORY (Secondary)

convulsion (duration) *1* yrs. *6* mos. *6* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *mine Blant*(Signed) *C. N. McElroy* M. D., 19 (Address) *1416 E. L. Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Int. Olivet Cemetery *4/24 1920*

20 UNDERTAKER

J. G. Moran ADDRESS *3000 E. Baltore*

mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 23 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42529

CERTIFICATE OF DEATH.

64 D42529

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2413 E Fairmount ST.; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE

No.

ST.

WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 4 1/2 yrs. mos. ds.How long in U. S., if of foreign birth 4 1/2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 1857

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

63

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Insurance

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Agent

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Balt
md

10 NAME OF FATHER

Jos. Goetzinger

11 BIRTHPLACE OF FATHER (city or town)
(State or country)Balt
md

12 MAIDEN NAME OF MOTHER

Elizabeth

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

M.P.

14

Informant
(Address)

Mrs Anna Goetzinger

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-22-1920

17

I HEREBY CERTIFY, That I attended deceased from
Apr 2, 1920, to Apr 22, 1920,
that I last saw him alive on Apr 22, 1920,
and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
PancreasCONTRIBUTORY
(Secondary)Duration yrs. mos. ds. 20
duration yrs. mos. ds. 118 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Dr. Blader

M. D.

1920 (Address)

14376 B May

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Church

Apr 24 1920

20 UNDERTAKER

George F. Routh

ADDRESS

1235 N. Bay

APR 23 1920

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42530

D42530

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ...)

2-FULL NAME

(Residence in Baltimore: No. ...)

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-STATUS *Married*
6-DATE OF BIRTH *June 16th 1891*
7-AGE *29* yrs. *10* mos. *5* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Chauffeur*
(b) General nature of industry, business, or establishment in which employed (or employer) *086*

9-BIRTHPLACE, (State or Country), *Calver Md*

10-NAME OF FATHER *F. Oehring*
11-BIRTHPLACE OF FATHER (State or Country), *Germany*
12-MAIDEN NAME OF MOTHER *P. Nebel*
13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *F. Oehring*
(Address) *1820 Hazard Ave*

15-

APR 24 1920

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

2, 19*20*
(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ...
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said ...
(Inquest, au-

opsy find that said deceased came to ... death
topsy or inquiry
on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism by
collision on
Blair Road
(Cause of death) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Signed) *H. J. ...* M. D.
(Coroner.)

4-24, 19*20* (Address) *...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Bell Cemetery
April 24 1920
George H. Ruth
1735 Hazard Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42531

CERTIFICATE OF DEATH.

REGISTERED NO. C

D42531

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

1116 E. Lexington
Mamie Bostie (or Bodick)
1116 E. Lexington

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, (Month) (Day) (Year)

7-AGE, (If LESS than 1 day, ... hrs. or ... min.?)

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER, 12-MAIDEN NAME OF MOTHER, 13-BIRTHPLACE OF MOTHER

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) (Address)

15- Robert P. Harrison, Registrar.

APR 24 1920

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows:

Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death, In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death? Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42532

D42532

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1025 Eastern Ave ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Katherine Eversmeier

(a) RESIDENCE. NO.

1025 Eastern Ave ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofFrederick Eversmeier6 DATE OF BIRTH (month, day, and year) Oct 19, 18507 AGE Years 70 Months 4 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Germany10 NAME OF FATHER Sebastian Muly11 BIRTHPLACE OF FATHER (city or town)
(State or country)Germany

12 MAIDEN NAME OF MOTHER

Not known13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Not known14 Informant Frederick Eversmeier
(Address) 1025 Eastern Ave15 Filed APR 24 1920 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1920

17

I HEREBY CERTIFY, That I understand deceased fromJan. 21, 1920, to April 21, 1920,
that I last saw her alive on April 21, 1920,
and that death occurred, on the date stated above, at 2:50 P.m.

The CAUSE OF DEATH* was as follows:

Senile degeneration(duration) yrs. 3 mos. ds.CONTRIBUTORY
(Secondary)(duration) yrs. 1 mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of —Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

, 19 (Address)

By: Dr. J. P. Smith, M.D.
1307 A. E. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Carmel Cem.April 24, 1920

20 UNDERTAKER

ADDRESS

He Sander House1208 E. St.

mation should be carefully examined, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D42533

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42533

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 N. Bond

ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Catherine Hudgins

(a) RESIDENCE. NO.

1206 N. Bond

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

61 yrs. 10 mos. 5 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

(or) WIFE of

Thomas E. Hudgins

6 DATE OF BIRTH (month, day, and year)

June 18, 1858

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

61

10

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

Md.

10 NAME OF FATHER

Casper Brandao

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mr. Alf.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mr. Thomas E. Hudgins
1206 N. Bond St.
Robert P. Harrison,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 23, 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr 2, 1920, to Apr 23, 1920,

that I last saw him alive on Apr 22, 1920,

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Septicemia & Endocarditis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Uremic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Microscopic

(Signed)

J. N. Thomas, M. D.
122 E. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Lawn Cemetery

Apr. 26, 1920

20 UNDERTAKER

Henry Horck Sun

ADDRESS

301 E. Eager St.

APR 24 1920

Burial Permit Clerk.

Registrar

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificates.

D42534

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42534

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1746 E. 25th ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Wilkinson(a) RESIDENCE. NO. 1746 E. 25th ST. 9 WARD. (Usual place of abode) (If nonresident give city or town and State)Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced (or) WIFE of William W. Wilkinson

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 50 Months 2 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife(h) General nature of industry, business, or establishment in which employed (or employer) 007

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co Md (State or country)10 NAME OF FATHER Chas H. Wilkinson11 BIRTHPLACE OF FATHER (city or town) Harford Co Md (State or country)12 MAIDEN NAME OF MOTHER Bulah Numbers13 BIRTHPLACE OF MOTHER (city or town) Harford Co Md (State or country)14 Informant William W. Wilkinson (Address) 1746 E 25th St15 Filed Robert P. Harrison,

Registrar

Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 192017 I HEREBY CERTIFY, That I attended deceased from April 1st, 1919, to April 23rd, 1920, that I last saw her alive on April 23rd, 1920, and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Based on's Disease(duration) yrs. 6 mos. ds.CONTRIBUTORY Myocard (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? ✓Did an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? (Signed) D. C. Hancock, M. D.19 (Address) 1924 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baker Bur. Harford Co Md DATE OF BURIAL Apr. 25 192020 UNDERTAKER Harry W. Ehlen ADDRESS 1944 W. North Ave

Information should be carefully reported. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

APR 24 1920

D42535

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42535

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. *Ellemonk Ave. near Frederick Road* WARD)2-FULL NAME *Margaret Ann Frizzell*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *Ellemonk Ave. near Frederick Road* St.; *50* yrs. *50* mos. *50* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE *married*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)6-DATE OF BIRTH *April 29 1856*
(Month) (Day) (Year)7-AGE *64* yrs. *—* mos. *—* ds. or min.?
If LESS than 1 day, hrs. min.?8-OCCUPATION
(a) Trade, profession or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer) *037*9-BIRTHPLACE (State or country) *Frederick Co. New London*PARENTS
10-NAME OF FATHER *Henkle Frizzell*
11-BIRTHPLACE OF FATHER (State or country) *Barrett Co. Md*
12-MAIDEN NAME OF MOTHER *not known*
13-BIRTHPLACE OF MOTHER (State or country) *1*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *L. H. Frizzell*
(Address) *State D.P.O.*15- Robert P. Harrison,
APR 24 1920
191
Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *April 23 1920*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Feb 11 1920*, to, *April 23 1920*, that I saw her alive on *April 21 1920*, and that death occurred, on the date stated above, at *10:50 a.m.*
The CAUSE OF DEATH* was as follows:*Carcinoma, involving the left breast axillary glands and mediastinal glands*
(Duration) *1* yrs. *—* mos. *—* ds.Contributory (SECONDARY)
(Duration) *—* yrs. *—* mos. *—* ds.(Signed) *Charles G. G. G.* M. D.
April 24 1920 [Address] *114 W. Larnach St.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *—* yrs. *—* mos. *—* ds. State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Landon Park* DATE OF BURIAL *Apr 26 1920*20-UNDERTAKER *George J. Smith* ADDRESS *1000 R. Bayoth St*

N. B.—Every item of information should be carefully supplied. Exact state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state CAUSE OF DEATH is very important. See instructions on back of certificate.

D42536

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42536

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 885 N. Howard ST.; 11 WARD)

REGISTERED No. C

2-FULL NAME

Sarah Teblman

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 885 N Howard St.; 1 yrs., ✓ mos., ✓ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Widow

6-DATE OF BIRTH,

✓ ✓ 1865
(Month) (Day) (Year)

7-AGE,

55 yrs., ✓ mos., ✓ ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Retired Restaurant
Keeper 1869-BIRTHPLACE,
(State or Country),England

10-NAME OF FATHER,

Don't Know11-BIRTHPLACE OF FATHER
(State or Country),Don't Know

12-MAIDEN NAME OF MOTHER

Don't Know13-BIRTHPLACE OF MOTHER
(State or Country),Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. B. Lamm(Address) 1216 John St

15-

Robert P. Harrison,Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 22, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Apr 21st 1920, to Apr 22nd 1920, that I saw h e alive on Apr 22 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute intestinal
Obstruction(Duration) ✓ yrs., ✓ mos., ✓ ds.CONTRIBUTORY Intussusception
(Secondary)(Duration) ✓ yrs., ✓ mos., ✓ ds.(Signed) Chas. J. Kell M. D.Apr 22, 1920 (Address) 2216 W. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ✓ yrs., ✓ mos., ✓ ds. In the State ✓ yrs., ✓ mos., ✓ ds.

Where was disease contracted, if not at place of death?

Former or usual residence England

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Landon Park Cem.4.24.1920

20-UNDERTAKER

ADDRESS

David Bondheim118 W. Mt Royal

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

APR 24 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42537

D42537

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #313 N. Greene St. ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Cecelia Gibney.(a) RESIDENCE. NO. #313 N. Greene St. ST. 4 WARD. 7 (RESIDENT)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 10 mos. 20 ds. How long in U. S., if of foreign birth? 54 yrs. 10 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female. 4 COLOR OR RACE White. 5 Single, Married, Widowed, or Divorced (write the word) (Single)5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)6 DATE OF BIRTH (month, day, and year) June-3-1865.7 AGE Years 54 Months 10 Days 20 If LESS than 1 day, hrs. — min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (None)(b) General nature of industry, business, or establishment in which employed (or employer) (None)(c) Name of employer (None)9 BIRTHPLACE (city or town) Baltimore City. (State or country) Maryland.10 NAME OF FATHER Patrick Gibney11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Ireland.12 MAIDEN NAME OF MOTHER Mary A. Byrne13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Ireland.14 Informant Mrs. Eliz. A. McMahon, (sister) (Address) #313 N. Greene St.Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1920

17

I HEREBY CERTIFY, That I attended deceased from April 1st, 1920 to April 23, 1920, that I last saw him alive on April 22, 1920, and that death occurred, on the date stated above, at 4 a m. The CAUSE OF DEATH* was as follows:Senile dementia with depression(duration) yrs. 21 mos. — ds.CONTRIBUTORY Arterio Sclerosis (Secondary)(duration) yrs. — mos. — ds.

15 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? Definite symptoms(Signed) Charles O. Morrison, M. D.Date, 1920 (Address) 5 E. Rad St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral CemeteryApr/26/20

20 UNDERTAKER

ADDRESS

STEWART & MOWEN COMPANY(WILLIAM F. WOODEN, Successor)108 W. NORTH AVE.

APR 24 1920

Information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42538

D42538

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1419 Cooksie

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Norman B. Mallonee

(a) RESIDENCE. NO.

1419 Cooksie

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 11

mos.

ds.

How long in U. S., if of foreign birth

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 25, 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

11

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Charles B. Mallonee

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Brooklyn, Md.

12 MAIDEN NAME OF MOTHER

Carrie W. Mundie

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Essex Co., Va.

14

Informant (Address)

Charles Mallonee
1419 Cooksie St.

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 22, 1920

17

HEREBY CERTIFY, That I attended deceased from

April 13, 1920, to April 22, 1920,

that I last saw him live on April 22, 1920,

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Influenza & Lobar Pneumonia
(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

Convulsions

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

At place of death

If not at place of death?

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Physical findings

(Signed)

Harry Bleicher, M.D.

19 (Address)

1215 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill Cem.

4/24/20

20 UNDERTAKER

ADDRESS

M. Y. Flynn

422 Light

Information should be given in plain terms, so that it may be properly understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

APR 24 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42539

D42539

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2223 Druid Hill Ave.)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2223 Druid Hill Ave.)

46 yrs., 10 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

June 5, 1873

(Month)

(Day)

(Year)

7-AGE

43

yrs.

10

mos.

18

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country)

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

APR 24 1920

Filed

1920

Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr. 23, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 21, 1920, to Apr. 23, 1920,

that I saw her alive on Apr. 23, 1920,

and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Coma

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) W. C. Carr M. D.

Apr. 24, 1920 (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

In D Auburn Cemetery Apr. 26 1920

20-UNDERTAKER ADDRESS

George H. Holland 1631 Druid Hill Ave

D42540

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42540

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 N. Mount ST.: 15 WARD)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl Nash(a) RESIDENCE. NO. 1707 N. Mount ST., _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 11mos. 22

How long in U. S., if of foreign birth?

yrs. _____

mos. _____

ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE Lat5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr.6 DATE OF BIRTH (month, day, and year) March 22, 1919

7 AGE

Years

Months

Days

If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Brown Nash11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)12 MAIDEN NAME OF MOTHER Lucy Hardy13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14

Informant (Address) Lucy Nash
1707 N. Mount

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1920

17

I HEREBY CERTIFY, That I attended deceased from Apr 22, 1920, to Apr 22, 1920, that I last saw him alive on Apr 22, 1920and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(duration) _____ yrs. _____ mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? HomeDid an operation precede death? No, Date of _____Was there an autopsy? NoWhat test confirmed diagnosis? Regular(Signed) F. L. Quirk, M. D.(Address) 1313 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

MT AuburnAPR 24 1920

20 UNDERTAKER

JAMES H. DENNIS

ADDRESS

1303 PRESTMAN ST.

Information should be carefully supplied in plain terms, so that it may be properly classified. See instructions on back of certificates.

APR 24 1920

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42541

CERTIFICATE OF DEATH.

D42541P

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 W. Mulberry

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Stallo

(a) RESIDENCE. No. 115 W. Mulberry

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 7 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Sept 4 1888
7 AGE 32 Years 7 Months 19 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk - Book-keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 008

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER George Stallo

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Wilhelmina Debring

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)14 Informant Mrs. Ernest Taylor
(Address) 115 W. Mulberry Street

15 Filed APR 24 1920 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/23 1920

17

I HEREBY CERTIFY, That I attended deceased from

Oct 19 1919, to Apr 20 1920
that I last saw him alive on Apr 5 1920,

and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? microscopic

(Signed) Geo. A. Lewis, M. D.

, 19 (Address) 1018 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

4/26, 1920

20 UNDERTAKER

ADDRESS

Henry W. Mears & Son 805

N. Calvert

St.

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

D42542

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42542

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1132 Laurel ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1132 Laurel ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Purdy Gallon6 DATE OF BIRTH (month, day, and year) Dec. 20, 1877

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4342

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

James T. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mary Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Purdy Gallon1132 Laurel St.

APR 24 1920

19

Registrar

Robert P. Harrison,Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 - 1920

17

I HEREBY CERTIFY, That I attended deceased from April 16, 1920 to April 22, 1920,that I last saw her alive on April 22, 1920,and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert P. Harrison, M. D.4.22.1920 (Address) 120 1/2 Airquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt ZionApril 25 - 1920

20 UNDERTAKER

William Cook

ADDRESS

503 E. North

Information should be carefully supplied. See instructions on back of certificates.

D42543

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42543

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (Municipal Tuberculosis Hospital 22nd WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wesley Miner

(a) RESIDENCE. NO. 521 N. Paca St.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., If of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE

Years

Months

Days

If LESS than
1 day,.....hrs.
or.....min.

43

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town)
(State or country)

Maryland

10 NAME OF FATHER

Wm. Miner

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Peggy Barber

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

North Carolina

14

Informant
(Address)Hospital Records
M.T.H.

15

Filed

Robert P. Harrison

Registrar

APR 24 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 6, 1920, to April 20, 1920

that I last saw him alive on April 20, 1920

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed)

George R. Wilkerson, M. D.
4-20-20 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Pulaski
20 UNDERTAKERApril 24 1920
ADDRESS

Charles B. Jones

24 Pine

CAUSE OF DEATH in plain terms, as far as possible, is to be stated on back of certificate. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE, ⁰⁶¹ D42544

D42544

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1831 Hanover ST. 23 WARD)

2-FULL NAME Emmett S. Hartline

(a) RESIDENCE. NO. 1831 Hanover ST. 23 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

7

mos.

11

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-23-20

17

I HEREBY CERTIFY, That I attended deceased from April 16, 1920, to April 23, 1920, that I last saw him alive on April 23, 1920, and that death occurred, on the date stated above, at 10:20 A. M. The CAUSE OF DEATH* was as follows:

Meningitis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & laboratory.

(Signed)

44 23 1920

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates.

APR 24 1920

D42545

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42545

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp.* ST.: *9* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Ruby P. Powell*(a) RESIDENCE, NO. *9 Little Place* CITY *MD.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *11* yrs. mos. ds.

How long in U. S., if of foreign birth? * yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *James E. Powell*6 DATE OF BIRTH (month, day, and year) *Dec 7-1889*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *31 4 16*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *va*10 NAME OF FATHER *William Mann*11 BIRTHPLACE OF FATHER (city or town) (State or country) *va*12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *va*

PARENTS

14 Informant (Address) *James E. Powell*

APR 24 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 23 1920*17 I HEREBY CERTIFY, That I attended deceased from *March 14*, 1920, to *April 23*, 1920,that I last saw him alive on *April 23*, 1920,and that death occurred, on the date stated above, at *8:00 P.m.*The CAUSE OF DEATH* was as follows: *Myocarditis*(duration) yrs. mos. ds. *acute*CONTRIBUTORY (Secondary) *Acute Thyroid tuberculosis*(duration) yrs. mos. ds. *1 mos. 5 ds.*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *April 5-20*Was there an autopsy? *no*What test confirmed diagnosis? *Clinical symptoms*(Signed) *J. T. Owen* M. D.19 Address *St. Joseph's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral**4-26-1920*

20 UNDERTAKER

ADDRESS *517 N**H. B. Branning Son**Schneider St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

BRANHAM

CERTIFICATE OF DEATH.

D42546

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Med. Sec. Hospital* ST. *24* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs Gladys Branham

(a) RESIDENCE. NO.

*133**Settings St.* ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

19 yrs.

mos.

24 ds.

How long in U. S., if of foreign birth?

19 yrs.

mos.

24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Widow of Clifton M. Branham*

6 DATE OF BIRTH (month, day, and year)

March 29/1901

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*19**24*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Balto Md.*

10 NAME OF FATHER

*Clifton Clarke*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Balto Md.*

12 MAIDEN NAME OF MOTHER

*Catherine McCain*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Balto Md.*

14

Informant
(Address)*Robert P. Harrison,*

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-23* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

4/23, 1920, to *4/23*, 1920,that I last saw him alive on *4/20*, 1920,and that death occurred, on the date stated above, at *150 P.* m.

The CAUSE OF DEATH* was as follows:

Post partum Eclampsia(duration) yrs. mos. *1* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?*Home.*Did an operation precede death? *no* Date of *-*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

Clifton Clarke

M. D.

19 (Address)

Med. Sec. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Western Cem.**April 24 1920*

20 UNDERTAKER

M. H. Flynn

ADDRESS

1422 Light

tion should be carefully supplied. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important.

APR 24 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42547

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Provident Hospital* ST. *17* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *925 Shields Pl.* St. *15* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.) *Single*

6-DATE OF BIRTH,

Unknown, 1887
(Month) (Day) (Year)

7-AGE

33 yrs. mos. ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*General*
*Housework*9-BIRTHPLACE,
(State or Country),*Bedford Co Va*

10-NAME OF FATHER,

*Armistead Tucker*11-BIRTHPLACE OF FATHER
(State or Country),*Va*

12-MAIDEN NAME OF MOTHER

*Susan Johnson*13-BIRTHPLACE OF MOTHER
(State or Country),*Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mella Shivers*(Address) *810 Hampton St*

15-

Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April, *22*, 19*20*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr 12 19*20*, to *Apr 22* 19*20*,
that I saw her alive on *Apr 22* 19*20*,
and that death occurred, on the date stated above, at *4 P.* m.

The CAUSE OF DEATH* was as follows:

Miscarriage + Retained Placenta - (Unavoidable)(Duration) yrs. mos. *15* ds.CONTRIBUTORY
(Secondary)(Duration) yrs. mos. *11* ds.(Signed) *H. P. Hughes* M. D.*Apr. 12, 1920* (Address) *724 W. Saratoga*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

For Mr. Guburn

20-UNDERTAKER

Sam'l Hensley

DATE OF BURIAL,

Apr 24, 19*20*

ADDRESS

578 W. Kille

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

APR 24 1920

D42548

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42548

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1928 White St. ST.; 70 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 1928 White St.; 35 yrs., 6 mos., 15 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F 4-COLOR OR RACE, Cal 5-SINGLE, MARRIED, married, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, October, 1869.
(Month) (Day) (Year)7-AGE, 51 yrs., 6 mos., 15 ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) 0379-BIRTHPLACE, (State or Country), St. Mary's Co. Md.10-NAME OF FATHER, Samuel Dancy11-BIRTHPLACE OF FATHER (State or Country), Md.12-MAIDEN NAME OF MOTHER Elizabeth Young13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas H. Henderson(Address) 1928 White St. City15- Robert P. HarrisonFiled APR 24 1920 191. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April, 22, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from 4/18/1920 to 4/22/1920, that I saw her alive on 4/22/1920, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) yrs. mos. 15 ds.CONTRIBUTORY Paralysis
(Secondary)(Signed) James M. May M. D.
4/22/1920 (Address) 513 N. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount AuburnDATE OF BURIAL, April 25, 192020-UNDERTAKER John H. OwensADDRESS 5-38 12th Ave

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

D42549

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

152 ✓ D42549

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2476 Linwood Ave ST. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 2476 Linwood Ave ST. 6 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

5/20/20

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

2476 Linwood Ave Balt. Md

10 NAME OF FATHER

Walter E Andrysiak

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt Md

12 MAIDEN NAME OF MOTHER

Bertha B Sutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt. Md

14

Informant (Address)

Walter E Andrysiak 2476 Linwood Ave

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-23 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 20, 1920, to Apr. 23, 1920,

that I last saw him alive on Apr. 23, 1920,

and that death occurred, on the date stated above, at 4 pm m.

The CAUSE OF DEATH* was as follows:

Asphyxia Pallida

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Congenital

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

For E. J. Brady, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus Cemetery

4/24 1920

20 UNDERTAKER

ADDRESS

J. A. Moran

203 Baltimore

APR 24 1920

10. 42550

HEALTH DEPARTMENT—CITY OF BALTIMORE

10. 42550

CERTIFICATE OF DEATH.

1-PLACE OF DEATH USA General Hospital No.2

CITY OF BALTIMORE: (No. Fort McHenry, Md.)

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Basits, Pvt. Bat. B 77th F.A.

Ship to
(Residence ~~in Baltimore~~ Brownsville, Penna. Home Grindstone, Pa. St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male
4-COLOR OR RACE, White
5-SINGLE, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH, Unknown
(Month) (Day) (Year)

7-AGE, 21 yrs. - mos. - ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Soldier in U.S.
(b) General nature of industry, business, or establishment in which employed (or employer). Army 086

9-BIRTHPLACE, (State or Country), Mongahela City, Penna.

10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (State or Country), Unknown
12-MAIDEN NAME OF MOTHER Mrs. Mary Basits, Grindstone, Penna.
13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-APR 25 1920 ROBERT B. KAUTER
Filed 191. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 23, 1920, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 27, 1919, to April 23, 1920, that I saw him alive on April 23, 1920, and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

(1) Old GSW (slight) leg Lt. Flesh wound...
(2) Old wound contused knee left from horse being killed & falling on soldier knee. (3) Arthritis chronic tubercular left knee joint. (4) Meningitis tuberculous.
(Duration) yrs. mos. ds.

CONTRIBUTORY.....
(Secondary) (Duration) yrs. mos. ds.

(Signed) Thomas J. Leary, Major, M.C.
Apr. 24, 1920 (Address) Ft. McHenry, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Brownsville Pa 4/24, 1920

20-UNDERTAKER, ADDRESS

Max Lunsan Balto St

CAUSE OF DEATH in plain terms, so that it is important. See instructions on back of certificate.

D42551

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Church Home & Infirmary

REGISTERED NO.

CITY OF BALTIMORE: (No.

76 N. Broadway

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby, Pledge

(a) RESIDENCE. NO.

C N + 3

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or 5 min.

0

0

0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) C N + 3

(State or country)

76 N. Broadway Baltimore

10 NAME OF FATHER

Mr. James Pledge

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mary Lane

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Middleton

14

Informant

(Address)

15

APR 25 1920

ROBERT I. TRAUTER
Registrar

Baptist Church Clerk

STILL

15

D42551

ST.:

WARD)

ST.:

WARD.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 4 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 4 1920, to April 4 1920,

that I last saw him alive on April 4 1920

and that death occurred, on the date stated above, at 6:45 a.m.

The CAUSE OF DEATH* was as follows:

Removal of abortion; (spontaneous)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Op.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter S. Anderson M. D.

, 19 (Address) C.H.T. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Church Home & Infirmary

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42552

CERTIFICATE OF DEATH.

D42552

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 Peach Alley ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Hall(a) RESIDENCE. NO. 1022 Peach Alley ST. 23 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife dead6 DATE OF BIRTH (month, day, and year) 18487 AGE Years 62 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Passer(b) General nature of industry, business, or establishment in which employed (or employer) 086(c) Name of employer Unknown9 BIRTHPLACE (city or town) Westmoreland, Pa
(State or country) Pa10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Unknown

14

Informant Clara Grace
(Address) 1022 Peach Alley

15

APR 25, 1920

ROBERT F. MASTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1920

17

HEREBY CERTIFY, That I attended deceased from April 16 1920 to April 22 1920, that I last saw him alive on April 22 1920, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Disease (Coronary)CONTRIBUTORY (duration) yrs. mos. ds. 7
(Secondary) As the cause
(duration) yrs. mos. ds. 718 Where was disease contracted 1022 Peach Alley
if not at place of death?Did an operation precede death? NO Date ofWas there an autopsy? NOWhat test confirmed diagnosis? Charcot's sign(Signed) C. H. Fowler M. D.

712 Sharp Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mount Auburn Cem Apr 28 1920

20 UNDERTAKER

Samuel H. Hensley 218 W. 3rd St.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42553

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 N. Howard ST. 11 WARD)

2-FULL NAME

(Residence in Baltimore: No. 928 N. Howard St.; 46 yrs., 11 mos., 11 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

....., 1
(Month) (Day) (Year)

7-AGE,

53 yrs., 11 mos., 11 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

APR 25 1920 ROBERT B. KRAUTER
Filed..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 23, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 22 1920, to April 23 1920,that I saw him alive on April 22 1920,and that death occurred, on the date stated above, at 11 9 m.

The CAUSE OF DEATH* was as follows:

Coronary disease of the heart

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

4.23, 1920. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Ambrose Church Apr. 26, 1920.

20-UNDERTAKER

ADDRESS

James H. Hunsley 387 N. E. St.

CAUSE OF DEATH in plain terms, so that it is important. See instructions on back of certificate.

D42554

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42554

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 E. North Ave ST.: 9 WARD)

2-FULL NAME

Marion Wesley Killmon

(a) RESIDENCE. No.

1111 E. North Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single6 DATE OF BIRTH. (month, day, and year) Feb. 21/18997 AGE Years Months Days If LESS than 1 day, hrs. or min.
21 2 2 — — —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Steel Corporation

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland10 NAME OF FATHER Charles W Killmon11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland12 MAIDEN NAME OF MOTHER Elizabeth A White13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind14 Informant Charles W Killmon (Address) 1111 E. North Ave15 APR 25 1920 ROBERT K FLAUTE RegistrarBurial Permit 0107

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1920.

17

I HEREBY CERTIFY, That I attended deceased from

April 6, 1920, to April 23, 1920.that I last saw him alive on April 23, 1920.and that death occurred, on the date stated above, at 12-30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Spinal Exam.(Signed) Robert J. Green, M. D.424. 1920 (Address) 120 1/2 Disgust St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Charles Cemetery April 26, 1920

20 UNDERTAKER ADDRESS

John B. Spence, 1320 N. Broadway

N. B.—WRITE PLAINLY, WITH CARE. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D42555

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

St.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

Nov. 18, 1899.

(Month)

(Day)

(Year)

7-AGE,

21 yrs., 1 mos., 10 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Member.

159

9-BIRTHPLACE,

(State or Country),

Md.

10-NAME OF FATHER,

Conrad Batz

11-BIRTHPLACE OF FATHER,

(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Loretta Dwyer

13-BIRTHPLACE OF MOTHER

(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jno. Dwyer

(Address)

Baltimore

15-

APR 25 1920

ROBERT B. KRAUTH

Filed

101

Burial Permit

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr. 22, 1920.

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Riding a motor cycle
into an
automobile
accidentally.

CONTRIBUTORY (Secondary)

Fracture of skull

(Signed) J. Edgar Smith

(Coroner) M. D.

4-18-22 (Address) 910 Sepke St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

David Ridge Cemetery

20-UNDERTAKER

ADDRESS

J. F. China

N. B.—Every item of information furnished is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42556

CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

CITY OF BALTIMORE (No. ...)

2-FULL NAME

(Residence in Baltimore: No. ...)

Mary Ann Hospital
ST.: *11* WARD)
Hellon L. Duggs
518 Park Ave

St.: yrs. mos. ds.)
44 3

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <i>Male</i>	4-COLOR OR RACE, <i>col.</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <i>Single</i>
6-DATE OF BIRTH, <i>Oct 11, 1920</i> (Month) (Day) (Year)		
7-AGE, <i>33</i> yrs. <i>6</i> mos. <i>12</i> ds. If LESS than 1 day, ... hrs. or ... min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). <i>Scheffle</i>		

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

Balto Co Md
Eligh Duggs
Balto Co Md
Hora Derrick
Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

Seemore Duggs
Steve Macn
Md

15-

APR 25 1920

ROBERT A. BRADY

REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy, or inquiry.)

thereof and from the evidence obtained by said... (Inquest, au-

... find that said deceased came to... death... on the day stated above.

The CAUSE OF DEATH was as follows:
Homocidal, by own hand with pistol.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Signed) *John J. ...* M. D.
(Coroner.)

4-24, 1916 (Address)...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. ...

April 25 1920

20-UNDERTAKER

ADDRESS

J. F. ...

... Md

N. B.—Every item of information should be in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42557

CERTIFICATE OF DEATH.

D42557

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Hebrew Hosp.

ST.;

WARD) 6

REGISTERED NO. C

2-FULL NAME

Alter Caplan

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1836

E Fayette St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH

Unknown

1872

(Month)

(Day)

(Year)

7-AGE,

48

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

040

9-BIRTHPLACE,
(State or Country),

Russia

10-NAME OF FATHER,

Elya Caplan

11-BIRTHPLACE OF FATHER
(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. Lewis

(Address)

1411 E. Pratt St

15-

Filed

APR 25 1920

ROBERT E. BAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April

24th

1920.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 12th 1920, to April 24 1920,

that I saw him alive on April 24, 1920,

and that death occurred, on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis.

Tuberculous Meningitis.

12 days?

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

B. Sacks

M. D.

April 24, 1920

(Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 1836 E Fayette St

19-PLACE OF BURIAL OR REMOVAL,

Hebrew Cemetery

DATE OF BURIAL,

4/25, 1920

20-UNDERTAKER

Jack Lewis

ADDRESS

1411 E. Pratt St

CAUSE OF DEATH in plain terms important. See instructions on back of certificate.

D42558

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42558

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *207 Aisquith* ST.: *5* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Joseph Snowden

(a) RESIDENCE

No 207 Aisquith

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

colored

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

74 yrs

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

MD

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

MD

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MD

14

Informant (Address)

Mrs Handy (Maiden)
207 Aisquith St

15

*APR 25 1920**ROBERT B. BRADY*

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 23 1920

17 I HEREBY CERTIFY, That I attended deceased from

*March 25, 1920, to Apr 20, 1920,*that I last saw him alive on *Apr 20, 1920,*and that death occurred, on the date stated above, at *6:30 PM* m.

The CAUSE OF DEATH* was as follows:

Apoplexy

CONTRIBUTORY

(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. Edward Fisher M.D.

, 19

(Address)

1612 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Laurel Cemetery**4/25/20*

UNDERTAKER

Thos. White 113 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42559

D42559

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 679 Bradley ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Scott(Residence in Baltimore: No. 679 Bradley St St. 4 yrs. 4 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, Black 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct 27th, 1892
(Month) (Day) (Year)

7-AGE, 27 yrs. 5 mos. 26 ds. If LESS than 1 day,hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Laundry work
(b) General nature of industry, business, or establishment in which employed (or employer), Belvedere Hotel

9-BIRTHPLACE, (State or Country), Virginia10-NAME OF FATHER, Mr. Scott11-BIRTHPLACE OF FATHER (State or Country), Virginia12-MAIDEN NAME OF MOTHER Julia Whitney13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Scott(Address) 679 Bradley St

15-

Filed

APR 25 1920

ROBERT B. KRAUTER

191

BALTIMORE CITY REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 22nd, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 26th 1920, to April 22nd 1920, that I saw her alive on April 22nd 1920, and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Surgeon General Tuberculosis(Duration) 1 yrs. 1 mos. 1 ds.CONTRIBUTORY (Secondary) Hemorrhage & renal weakness(Duration) 1 yrs. 3 mos. 1 ds.(Signed) A. B. G. L. Scott M. D.Apr 22nd, 1920 (Address) 1110 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death,yrs.mos.ds. In the State,yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Ambrose ChurchDATE OF BURIAL, Apr 25, 192020-UNDERTAKER, David CarterADDRESS St. Ambrose

CAUSE OF DEATH in plain text on back of certificate. important. See instructions on back of certificate.

D42560

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *University Hospital* ST. *21* WARD)FULL NAME *Hilda Hazel Stuart*(Residence in Baltimore: No. *1423 Ward*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)6-DATE OF BIRTH, *Dec 4, 1915* (Month) (Day) (Year)7-AGE, *4 yrs. 4 mos. 19 ds.* If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Domestic* (b) General nature of industry, business, or establishment in which employed (or employer), *Domestic*9-BIRTHPLACE, (State or Country), *Baltimore Md*10-NAME OF FATHER, *Perry Stuart*11-BIRTHPLACE OF FATHER (State or Country), *Md.*12-MAIDEN NAME OF MOTHER, *Milda Brink*13-BIRTHPLACE OF MOTHER (State or Country), *Pa.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Milda Brink*(Address) *1423 Ward A*

15-APR 25 1920

Filed 191

ROBERT S. TRAUTER

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 23, 1920* (Month) (Day) (Year)17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)and that said deceased came to *her* death on the day stated above.

The CAUSE OF DEATH* was as follows:

*Accidental by burning on body while playing with matches*CONTRIBUTORY (Secondary) *accident*(Signed) *H. H. Gonsch* M. D. (Coroner.)*4-24-1920* (Address) *117 W. Saratoga St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, ... yrs. ... mos. ... ds. State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Luke's* DATE OF BURIAL, *Apr 25 1920*20-UNDERTAKER, *Samuel E. Carter* ADDRESS, *916*

N. B.—Every item of information furnished is important. See instructions on back of certificate.

D42561

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D42561

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

University Hospital

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ella Cole

(a) RESIDENCE. NO.

Hampstead Md.

ST.:

WARD.

Hampstead Md.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

11 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced ~~husband~~ of (or) WIFE of

Reynolds Cole

6 DATE OF BIRTH (month, day, and year)

1896

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

44

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Hampstead Maryland

10 NAME OF FATHER

Shadrach Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Hampstead Maryland

12 MAIDEN NAME OF MOTHER

Emma Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Hampstead Maryland

PARENTS

14 Informant (Address)

Edward C. Tipton
Hampstead Md.

15

APR 25 1920

ROBERT B. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24 1920

17

I HEREBY CERTIFY, That I attended deceased from

4/13 1920, to 4/24 1920,

that I last saw him alive on 4/24 1920,

and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Bilateral Salpingophoritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

Myocardial Insufficiency

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Hampstead Md. (P.)

Did an operation precede death? 2/8 Date of 4/13/20.

Was there an autopsy? No

What test confirmed diagnosis?

Operation of d. g. s.

(Signed)

Wm. Stein M. D.

4/24/20 (Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Grace Church, Balt. Co.

DATE OF BURIAL

Apr 27 1920

20 UNDERTAKER

W. J. Tucker & Sons

ADDRESS

North & Penna. Ave.
Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

D42562

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42562

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *6 Christ Row Arlington* ST. *151* WARD)

REGISTERED NO. C

2-FULL NAME *Infant of Mark & Eleanor Webbert*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *6 Christ Row Arlington* St.; yrs., mos. *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single* (Write the word)6-DATE OF BIRTH, *April 22, 1920*
(Month) (Day) (Year)7-AGE, yrs., mos. *2* ds. 11-LESS than 1 day, hrs. or min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer) *ooo*9-BIRTHPLACE, (State or Country), *Balto. and*10-NAME OF FATHER, *Mark Webbert*11-BIRTHPLACE OF FATHER (State or Country), *Penn*12-MAIDEN NAME OF MOTHER *Elinora O Becker*13-BIRTHPLACE OF MOTHER (State or Country), *Pittsburg Pa.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mark Webbert*(Address) *6 Christ Row*15- *APR 25 1920* *ROBERT B. KRAUTER*
Filed 191..... *ROBERT B. KRAUTER* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 24, 1920*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *April 22, 1920*, to *April 24, 1920*, that I saw her alive on *April 24, 1920*, and that death occurred, on the date stated above, at *1:30 P. m.* The CAUSE OF DEATH* was as follows:
congenital weakness & emphysema
(Duration) yrs. mos. *2* ds.CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.(Signed) *E. J. C. C.* M. D.
4-24, 1920 (Address) *1007 N. Bond*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore* DATE OF BURIAL, *April 26, 1920**Mc Henry Cemetery*20-UNDERTAKER *Henry Lutz* ADDRESS *1007 N. Bond*

CAUSE OF DEATH IN plain language important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42563

CERTIFICATE OF DEATH.

150

D42563

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

804 Greenmount Ave ST. 10

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Charles E. Slater

(Residence in Baltimore: No.

804 Greenmount Ave

St. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Single (Write the word.)

6-DATE OF BIRTH,

July 7, 1919 (Month) (Day) (Year)

7-AGE,

9 mos. 16 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Child

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Balto. md.

10-NAME OF FATHER,

John Slater

11-BIRTHPLACE OF FATHER

(State or Country),

Hanover Pa.

12-MAIDEN NAME OF MOTHER

Esther B. Jeffers

13-BIRTHPLACE OF MOTHER

(State or Country),

Balto. md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Slater

(Address)

804 Greenmount Ave

15-

APR 25 1920 ROBERT B. EBAUTER

Filed

191

REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 23, 1920 (Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mania

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary)

Calc. as heart failure

(Signed)

W. J. Riley

(Coroner.)

Apr 24, 1920 (Address) 1039 B...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Swan

DATE OF BURIAL,

April 24, 1920

20-UNDERTAKER

William Cook

ADDRESS

503 E. Hall Ave

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

Riley - 1639 Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42564

CERTIFICATE OF DEATH.

91 D42564

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 13 Harford Ave ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis W. Fieger

(a) RESIDENCE. No. 1813 Harford Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 ~~Single~~ Married, Widowed, or Divorced (write the word)

Male White Foreigner

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 6, 1912

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

7 4 17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Ferdinand Fieger

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt Md.

12 MAIDEN NAME OF MOTHER

Mary. Flor

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt Md.

14

Informant (Address)

Mr. F. W. Fieger 1813 Harford Ave

15

Filed APR 25 1920

ROBERT A. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23 1920

17

I HEREBY CERTIFY, That I attended deceased from Apr. 21, 1920, to Apr. 23, 1920, that I last saw him alive on Apr. 23, 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia (double)

(duration) yrs. mos. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? m Date of

Was there an autopsy? m

What test confirmed diagnosis

(Signed) Benj. S. Hayden M. D.

4/26 1920 (Address) 1216 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Church

April 26 1920

20 UNDERTAKER

ADDRESS

George J. Reith

735 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be understood by the layman. See instructions on back of certificates.

HEALTH DEPARTMENT CITY OF BALTIMORE

D42565

CERTIFICATE OF DEATH.

28 D42565
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 Dolphin ST.; 17 WARD)

2-FULL NAME

(Residence in Baltimore: No. 500 Dolphin St.; 3 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Colored

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

1884, 1.....
(Month) (Day) (Year)

7-AGE,

38 yrs. mos. ds. If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
Ordinary9-BIRTHPLACE,
(State or Country),MD

10-NAME OF FATHER,

Unknown11-BIRTHPLACE OF FATHER
(State or Country),MD

12-MAIDEN NAME OF MOTHER

Eliza13-BIRTHPLACE OF MOTHER
(State or Country),MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William T. Meigs(Address) 500 Dolphin St.

15-

APR 25 1920

Filed..... 191.....

ROBERT J. ELLIOTT
Registrar.

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 23, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

March 15 1920, to April 23 1920that I saw him alive on April 23 1920and that death occurred, on the date stated above, 12:00 pm.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed)..... M. D.

4/23, 1920 (Address) 924 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Wt Auburn

DATE OF BURIAL,

April 24, 1920

20-UNDERTAKER

Edward Ringgold

ADDRESS

1468 N. Carey

CAUSE OF DEATH—Important. See instructions on back of certificate.

D42566

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bayview Hospital

CITY OF BALTIMORE: (No.

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ada Brown

(a) RESIDENCE. NO.

566 Hunson

(Usual place of abode)

ST.:

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed

or Divorced (write the word)
Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1885

7 AGE

35

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Laundress.

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town)
(State or country)Baltimore
Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)Do.
Do.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Do.

14

Informant
(Address)Bayview Hospital
Baltimore, Md.

15

Filed

APR 25 1920

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 23, 1920

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 29, 1920, to April 23, 1920

that I last saw her alive on April 22, 1920

and that death occurred, on the date stated above, at 4:20 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminalis)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.
Paralysis.18 Where was disease contracted
If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) H. F. F. M. D.

4/22/1920 Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lafayette Cemetery

April 26, 1920

20 UNDERTAKER

ADDRESS

Edward Ringgold 1463 Mary

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42567

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1346 Calhoun St. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mariam Jones(a) RESIDENCE. NO. 1346 Calhoun St. ST., WARD.

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew6 DATE OF BIRTH (month, day, and year) 18 297 AGE Years Months Days If LESS than 1 day, hrs. or min. 91 26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work md wife(b) General nature of industry, business, or establishment in which employed (or employer) 086(c) Name of employer md9 BIRTHPLACE (city or town) (State or country) md10 NAME OF FATHER Wm Crofford11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa12 MAIDEN NAME OF MOTHER Rachell Watts13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

PARENTS

14 Informant (Address) Mrs. Humph
1346 Calhoun St.15 APR 25 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 192017 I HEREBY CERTIFY, That I attended deceased from April 10, 1920, to April 22, 1920, that I last saw her alive on April 22, 1920, and that death occurred, on the day stated above, at 4.35 P.m.

The CAUSE OF DEATH* was as follows:

apoplexy & Bright DiseaseCONTRIBUTORY (Secondary) Bright Disease (old age) (duration) 1 yrs. 2 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. J. W. Kennard M. D. Address 708 E. Enoch St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Laurel Cemetery April 25 1920

20 UNDERTAKER

Edward Rindgold Address 1463 N. Enoch

CAUSE OF DEATH in plain terms, so that it may be understood by the layman. See instructions on back of certificates.

D42568

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D42568

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 S Carey ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gene F. Riley(Residence in Baltimore: No. 106 S Carey St.; 19 yrs., 4 mos., 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M4-COLOR OR RACE W5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)6-DATE OF BIRTH, Nov 28, 1920

(Month)

(Day)

(Year)

7-AGE, 17 yrs., 4 mos., 26 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work ST. J. O'D.
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), Balt. Md.10-NAME OF FATHER, Michael Riley11-BIRTHPLACE OF FATHER (State or Country), Balt.12-MAIDEN NAME OF MOTHER Ch. Bosley13-BIRTHPLACE OF MOTHER (State or Country), Balt.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. Riley(Address) 106 S Carey St.

15-

Filed

191

ROBERT E. KRAUTER
Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 23, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from 3/1 1920, to 4/23 1920that I saw him alive on 4/22/20 1920,and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Asphyxia(Duration) 21 yrs., 6 mos., 26 ds.CONTRIBUTORY (Secondary) Th. Peritonitis(Duration) 6 yrs., 6 mos., 26 ds.(Signed) J. H. Smith M. D.4/23, 1920 (Address) 1305 N. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 17 yrs., 4 mos., 26 ds. In the State 19 yrs., 4 mos., 26 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Peters CemeteryDATE OF BURIAL, Apr. 26, 192020-UNDERTAKER Joseph B. CookADDRESS 1003 N. Paul St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42569

CERTIFICATE OF DEATH.

79 D42569

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Alhambra Apt B-1 ST.: 13 WARD)

2-FULL NAME

Fannie Strauss

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. Lake Drive Linden Ave St.: 35 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

April 23, 1856
(Month) (Day) (Year)

7-AGE,

64 yrs., mos., ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife 037

9-BIRTHPLACE, (State or Country),

Richmond Va.

10-NAME OF FATHER,

Isaac Bachrach

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Re Janette Steinheimer

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) I. H. Strauss

(Address) Baltimore Md

15-

Filed APR 25 1920

191

ROBERT A. ABRAHAM

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Feb 6 1924 to April 20 1920

that I saw her alive on April 23 1920,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) 6 yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., ds.

(Signed) Harry Adler M. D.

 , 191 (Address) 1218 Linden Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltz Hebrew Cem 4/25/20

20-UNDERTAKER

ADDRESS

J. Abrams & Co 161 Madison

important. See instructions on back of certificate.

D42570

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST.: *7* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John H. Morse

(a) RESIDENCE. NO.

*43 West End Ave N.Y.*WARD. *12th New York*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. *15* mos. *15* ds.

How long in U. S., if of foreign birth?

yrs. *15* mos. *15* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Minnie D Morse*

6 DATE OF BIRTH (month, day, and year)

May 21 1866

7 AGE

53

Years

11 Months*4* DaysIf LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

066

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Conn*

10 NAME OF FATHER

*Reley Morse*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Conn*

12 MAIDEN NAME OF MOTHER

*Hannah Evans*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Conn*

14

Informant
(Address)*Hospital Record
26-26*

15

Filed

*APR 25 1920**ROBERT E. SEABORN*

Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 20 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*April 10 1920, to April 20, 1920.*that I last saw him alive on *April 20, 1920.*and that death occurred, on the date stated above, at *2:50 a. m.*

The CAUSE OF DEATH* was as follows:

*Myocardial Insufficiency*CONTRIBUTORY
(Secondary)*Paroxysmal Tachycardia*18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Oliver Harris, M. D.*(Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Ansoms Conn, New York City

DATE OF BURIAL

APR 25 1920

20 UNDERTAKER

J. Ahrens & Co

ADDRESS

221 N. Broadway

CAUSE OF DEATH in plain terms, so that the physician's statement is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.,

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth?

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Widowed

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

APR 25 1920

ROBERT B. ELLIOTT

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1920

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1920 to April 24, 1920, that I last saw him alive on April 24, 1920, and that death occurred, on the date stated above, at 4:20 P. M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? YES

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D42572

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D42572

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1227 Madison ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Margaret Elizabeth Funch

(a) RESIDENCE

No. 1227 Madison ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Jesse Funch

6 DATE OF BIRTH (month, day, and year) Sept 8-1831

7 AGE Years 88 Months 7 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Lancaster Pennsylvania

10 NAME OF FATHER

Samuel Funch

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Chaplin

12 MAIDEN NAME OF MOTHER

Ann Funch

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Lancaster Pennsylvania

14

Informant (Address)

Mrs. Mary Funch 1227 Madison

15

Filed

APR 25 1920

ROBERT B. LEAUSER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23 1920

17 I HEREBY CERTIFY, That I attended deceased from

March 20, 1920, to April 23, 1920,

that I last saw him alive on April 22, 1920,

and that death occurred, on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Funch M. D.

13 (Address) 2008 Eastern Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lynn Mourny

Apr 26 1920

20 UNDERTAKER

ADDRESS

R. H. Funch

CAUSE OF DEATH in plain terms, as far as possible, on back of certificates. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST.: *9* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *John L. Stearns*(a) RESIDENCE No. *1578 Carroll St.* ST.: *12th* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Child*6 DATE OF BIRTH (month, day, and year) *Sept 22-1919*

7 AGE

Years

7 Months*2* Days

If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore, Md*10 NAME OF FATHER *Wm L. Stearns*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Maryland*12 MAIDEN NAME OF MOTHER *Mary Mc Guig*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md

14

Informant (Address)

Hospital Record

15

Filed

APR 25 1920

ROBERT B. LEAUTEUR

Registrar

Social Public Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 24 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*April 22, 1920, to April 24, 1920.*that I last saw him alive on *April 24, 1920.*and that death occurred, on the date stated above, at *3:45 a m.*

The CAUSE OF DEATH* was as follows:

Retropharyngeal Abscess(duration) yrs. mos. *7* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

*home*Did an operation precede death? *yes* Date of *Apr. 22, 1920*Was there an autopsy? *No*What test confirmed diagnosis? *Operation*(Signed) *Harold L. Higgins*, M. D.*Apr 24 1920* (Address) *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Pylesville Md**April 26 1920*

20 UNDERTAKER

ADDRESS

*Leo S. Brook**With a Bag*

CAUSE OF DEATH in plain terms, so that it can be read by the layman. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42574

CERTIFICATE OF DEATH.

120

D42574

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521. W. Pratt.

ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Lena. Moerkken.*(a) RESIDENCE. No. 1521. W. Pratt
(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female. White Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Henry Moerkken.*6 DATE OF BIRTH (month, day, and year) *July 23rd 1863*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
56 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House. Duties job

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Washington D. C.*10 NAME OF FATHER *Henry Konberger.*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Germany*12 MAIDEN NAME OF MOTHER *Unknown.*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Germany*14 Informant *Emmyas Charlet.*(Address) *1521. W. Pratt St.*

15 APR 26 1920 ROBERT A. KRAUTER

Registrar

Bacial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 23rd 1920*

17 I HEREBY CERTIFY, That I attended deceased from

*Mar 15th 1920 to Apr 23rd 1920*that I last saw him alive on *Apr 22nd 1920*and that death occurred, on the date stated above, at *9:30 A. m.*

The CAUSE OF DEATH* was as follows:

Nunna

CONTRIBUTORY (Secondary)

(duration) *2 yrs. 1 mos. ds.*(duration) *2 yrs. mos. ds.*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *[Signature]* M. D.Address *1302 N. Lombard*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Cemetery April 26. 1920

20 UNDERTAKER

Mr. Mrs. John W. Luefel 801 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42575

CERTIFICATE OF DEATH

9-091✓
REGISTERED No. C

D42575

PLACE OF DEATH

CITY OF BALTIMORE (No. *Sydenham Hospital* ST. *24* WARD)2-FULL NAME *James Stalling*(Residence in Baltimore: No. *1157 Risenstide Ave.* St. *5* yrs. *8* mos. *1* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

*white*5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*single*

6-DATE OF BIRTH

Aug. 23

(Month)

(Day)

(Year)

7-AGE

5 yrs. *8* mos. *1* ds.If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*none*9-BIRTHPLACE
(State or country)*MD*

10-NAME OF FATHER

*Arthur Stalling*11-BIRTHPLACE OF FATHER
(State or country)*MD*

12-MAIDEN NAME OF MOTHER

*Katherin Hall*13-BIRTHPLACE OF MOTHER
(State or country)*MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur Stalling

(Address)

1157 Risenstide Ave.

15

APR 26 1920

ROBERT A. KRAUTER

Filed

191

Burial Place REGISTER

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

April 24, 1920
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *April 17, 1920* to *April 24, 1920*that I saw him alive on *April 24, 1920*and that death occurred, on the date stated above, at *10:45 p.m.*

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal.(Duration) --- yrs. --- mos. *9* ds.Contributory
(SECONDARY)*Broncho pneumonia*(Duration) --- yrs. --- mos. *9* ds.

(Signed)

Bullaegawa M. D.*April 25, 1920*(Address) *Sydenham Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death --- yrs. --- mos. *7* ds. State --- yrs. --- mos. --- ds.Where was disease contracted, *at home.*

If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross Cemetery Apr 26, 1920

20-UNDERTAKER

ADDRESS

Mrs J E Evans 1468 8th Ave

N. B.-Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42576

CERTIFICATE OF DEATH.

79 D42576
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 Mosher ST. WARD)

2-FULL NAME William Burton Mosher

(Residence in Baltimore: No. 637 Mosher

St.; 30 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

C.C.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH,

1866
(Month) (Day) (Year)

7-AGE,

54 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Master - 186
Maritime9-BIRTHPLACE,
(State or Country),

Maryland

10-NAME OF FATHER,

Charles E. Mosher

11-BIRTHPLACE OF FATHER
(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Hartman Smith

13-BIRTHPLACE OF MOTHER
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Daniel E. Mosher
637 Mosher St.

15-APR 26 1920

ROBERT B. KRAUTER

Filed....., 191

BUTLER PATENT REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

4 23, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Apr. 15 1920, to Apr. 22 1920, that I saw him alive on Apr. 22 1920, and that death occurred, on the date stated above, at 1:15 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Pneumonia
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)(Signed) P. G. ... M. D.
Apr 23, 1920 (Address) 1534 E. H. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn

DATE OF BURIAL,

Apr. 26, 1920

20-UNDERTAKER

Samuel J. Hensley

ADDRESS

578 M. B. St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42572

CERTIFICATE OF DEATH.

28 D42573
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 429 St. Mary, ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Charles Williams

(Residence in Baltimore: No. 429 St. Mary St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Caucasian

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)
Married

6-DATE OF BIRTH.

Month 4, Day 18, Year 1862

7-AGE,

58 yrs., 1 mos., 19 ds.

If LESS than 1 day,

hrs. or mins.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Electrician
Contractor

9-BIRTHPLACE.

(State or Country),

MD

10-NAME OF FATHER,

Chas Williams

11-BIRTHPLACE OF FATHER

(State or Country),

MD

12-MAIDEN NAME OF MOTHER

Jane

13-BIRTHPLACE OF MOTHER

(State or Country),

MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Robert B. Kauter

(Address)

429 St. Mary St.

15

APR 26 1920

Filed....., 191.....

ROBERT B. KAUTER

Burial Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 23, 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 1, 1920, to April 23, 1920,

that I saw him alive on April 23, 1920,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Tuberculosis
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

R. B. Kauter M. D.

4-23-1920. (Address) 924 Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn Cem

DATE OF BURIAL,

Apr 26, 1920

20-UNDERTAKER

Samuel T. Kauter

ADDRESS

578 Madison St

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42578

CERTIFICATE OF DEATH.

120 ✓
D42578
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 Park Ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William R. Wagner(Residence in Baltimore: No. 1711 Park Ave St.; 48 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widow
(Write the word.)6-DATE OF BIRTH, July 31, 1870
(Month) (Day) (Year)7-AGE, 49 yrs., 8 mos., 24 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Meal 045
(b) General nature of industry, business, or establishment in which employed (or employer). Merchant9-BIRTHPLACE,
(State or Country), Pa10-NAME OF FATHER, Jacob Wagner11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER Adaline Schlemmer13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna R. Wagner(Address) 1711 Park Ave

15-APR 26 1920 ROBERT I. LEAUTE

Filed..... 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 24, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Apr 7 1920, to Apr 24 1920, that I saw him alive on Apr 23 1920, and that death occurred, on the date stated above, at 4A m. The CAUSE OF DEATH* was as follows:Chronic Bright's, entered sepsis
Septal
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY (Secondary) uræmia
(Duration)..... yrs..... mos..... ds.(Signed) Investigator M. D. Apr 25, 1920 (Address) 1025 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, York Pa DATE OF BURIAL, April 27, 192020-UNDERTAKER Chas E. Bruck ADDRESS 802 Madison Ave

D42579

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Howard Kelly Hospital* ST.; *14* WARD)2-FULL NAME *Mrs. Thomas Stevens*(Residence in Baltimore: No. *1418 Eutan Place* St.; *2* yrs., *2* mos., *2* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *widow* (Write the word.)6-DATE OF BIRTH, *Dec 12*, 1877 (Month) (Day) (Year)7-AGE, *42* yrs., *4* mos., *12* ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer) *do*9-BIRTHPLACE, (State or Country), *England*10-NAME OF FATHER, *Trusley*11-BIRTHPLACE OF FATHER (State or Country), *England*12-MAIDEN NAME OF MOTHER *Susan Field*13-BIRTHPLACE OF MOTHER (State or Country), *England*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James W. Irons*(Address) *Elizabeth H. J.*

15-

Filed

APR 26 1920

ROBERT E. FRANK

Burial Per Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 24*, 1920 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1*, 19*19*, to *April 24* 19*20*, that I saw her alive on *April 24* 1920, and that death occurred, on the date stated above, at *11:30* a.m.

The CAUSE OF DEATH* was as follows:

Carotid artery laceration
(Duration) *2* yrs., *2* mos., *2* ds.CONTRIBUTORY (Secondary) *Hemorrhage*(Signed) *Robert E. Frank* M. D. *April 24*, 1920 (Address) *1418 Eutan Pl.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, *2* yrs., *2* mos., *2* ds. In the State *2* yrs., *2* mos., *2* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Gainesville Fla.*19-PLACE OF BURIAL OR REMOVAL, *Gainesville Fla.* DATE OF BURIAL, *4/26/20* 192020-UNDERTAKER *Chas. E. Frank* ADDRESS *802 Madison*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42580

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1108 W. Lexington* ST.: *18* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1108 W. Lexington* St.: *51* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *Al* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

April *23*, *1879*
(Month) (Day) (Year)

7-AGE

41 yrs. mos. ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Housewife 037*
(b) General nature of industry, business, or establishment in which employed (or employer) *None*

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Leaster Bundy*(Address) *1108 W. Lexington St.*

APR 26 1920

ROBERT B. KRAUTER

Filed..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April *23*, *191*^{*20*}
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 15* *191*^{*20*}, to *April 23* *191*^{*20*}, that I saw *her* alive on *April 23* *191*^{*20*}, and that death occurred, on the date stated above, at *10* m.

The CAUSE OF DEATH* was as follows:

Ch. Substituted Nephritis
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Signed) *J. P. Hackett* M. D.
4/24, 191... (Address) *117 N. Camden*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS *1140*

D42581

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

61-001 D42581

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 W. Mulberry

ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morgan Sylvester Thompson

(a) RESIDENCE. No. 1610 W. Mulberry St.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

Negro

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

Feb 14 - 12 17

7 AGE

Years

Months

Days

If LESS than

2

2

16.

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md.

10 NAME OF FATHER

Alphonso Thompson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Annie Arundle Co.

12 MAIDEN NAME OF MOTHER

Alene Blake

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

St. Mary's County

14

Informant

Alene Thompson

(Address)

1610 W. Mulberry St.

15

APR 26 1920

ROBERT E. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1920

17

I HEREBY CERTIFY, That I attended deceased from April 23, 1920, to April 24, 1920.

that I last saw him alive on April 24, 1920.

and that death occurred, on the date stated above, at 5:15 pm.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal Meningitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical examination

(Signed) Walter D. Jackson, M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn

APR 26 1920

20 UNDERTAKER

ADDRESS

JAMES H. DENNIS

1303 PRESTMAN ST.

CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42582

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 N Madeira ST.; 6 WARD)

2-FULL NAME

Ada Champness

(a) RESIDENCE. No.

403 N Madeira

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

FemaleWhite

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofAndrew Champness

6 DATE OF BIRTH (month, day, and year)

Dec 1888

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

314

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workHousewife(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Balto Md

10 NAME OF FATHER

John Gill11 BIRTHPLACE OF FATHER (city or town)
(State or country)Balto Md

12 MAIDEN NAME OF MOTHER

Kate Starkey13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Balto Md

14

Informant
(Address)Andrew Champness
403 N Madeira St

15

APR 26 1920

ROBERT B. TRAUTER
Registrar

Baltimore Health Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 22 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 22nd, 1920, to April 22nd, 1920.That I last saw her alive on April 22nd, 1920.and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Ther pueral & clamped(duration) yrs. mos. ds. 2 hoursCONTRIBUTORY
(Secondary)Overfed & plumped(duration) yrs. mos. ds. 2 mos.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. B. Legler, M. D.

192 Address

830 N Broadway*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

LorraineApril 26 1920

20 UNDERTAKER

Millard B Callender

ADDRESS

1760 Bank St

CAUSE OF DEATH is printed on back of certificates. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D42583

CERTIFICATE OF DEATH.

157 D42583

PLACE OF DEATH

CITY OF BALTIMORE (No. 1917 Somerset St. 9

WARD)

FULL NAME

Baby Curtis
1917 Somerset

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female 4-COLOR OR RACE, col. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Baby.

6-DATE OF BIRTH,

April 24, 1920
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day,
2 hrs. or... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Baby odd

9-BIRTHPLACE,
(State or Country),

Balls

10-NAME OF FATHER, Heyward Curtis

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Rosa Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosa Curtis

(Address) 1917 Somerset

15-APR 26 1920 ROBERT F. KRAUTER

Filed 101 Burial Home

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr 26, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by... (Inquest, au-

topsy or inquiry.) and that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Jones, M. D.

(Coroner.) 4-26-1920 (Address) 9 E. 1st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Lanier Cemetery

DATE OF BURIAL,

Apr 26, 1920

20-UNDERTAKER

ADDRESS

R. B. Gross 1405 McElherry St

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificate.

D42581

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42581

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Municipal Tr. Hspt.* ST.: *28* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Milton W. Swift

(a) RESIDENCE. NO.

1899 Eastern Ave.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

*Widowed*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Not Recorded*

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*60*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborn

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore*

10 NAME OF FATHER

*W. R. Swift*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Balt*

12 MAIDEN NAME OF MOTHER

*Unknown*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Unknown*

14

Informant
(Address)*Thos. R. R. R.*

15

Filed

APR 26 1920

ROBERT F. LAUTER

Registrar

Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 25 1920

17

I HEREBY CERTIFY, That I attended deceased from

*June 6 1917 to April 24 1920*that I last saw him alive on *April 24 1920*and that death occurred, on the date stated above, at *11:45 p.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) *4* yrs. *4* mos. *ds.*CONTRIBUTORY
(Secondary)(duration) *4* yrs. *4* mos. *ds.*18 Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Positive Sputum*

(Signed)

George R. Wilbur, M. D.

, 19

(Address) *W. T. H. Balt. City*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mount Carmel

DATE OF BURIAL

April 26 1920

20 UNDERTAKER

Peter Nicolaus

ADDRESS

2046 Eastern

D42585
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D42585
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1528 E. Biddle ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1528 E. Biddle ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April 23, 20*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md.*10 NAME OF FATHER *Frank B. Moran*11 BIRTHPLACE OF FATHER (city or town) (State or country) *New York N.Y.*12 MAIDEN NAME OF MOTHER *Betty Y. Barnes*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Mass*14 Informant *Frank B. Moran* (Address) *1528 E. Biddle*15 FILE *APR 26 1920* *ROBERT B. FRASER**BUTLER PRINTING CO.*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 23, 1920*

17 I HEREBY CERTIFY, That I attended deceased from

19 to 19 that I last saw h alive on 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: *7 months fetus*

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *none*Was there an autopsy? *none*What test confirmed diagnosis? *none*(Signed) *J. H. Wagner, M. D.*(Address) *1206 E. Preston*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER *CONSUMPTION Health,*

ADDRESS

APR 24 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42586

CERTIFICATE OF DEATH.

48✓

D42586

(PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME.

(Residence in Baltimore: No.

ST.:

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: (yrs. 40) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant):

(Address):

15-

Filed

APR 26 1920

ROBERT B. FRAUTER

BUREAU OF VITAL STATISTICS

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an.....

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....

(Inquest, au-

topsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

(Coroner.)

Apr 23 1920

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

D42587

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79
D42587
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2234 Eastern Ave ST.; 1 WARD)

2-FULL NAME

Edwin Beck(Residence in Baltimore: No. 2234 Eastern Ave St.; 14 yrs., 1 mos., 14 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH, March 14, 1868
(Month) (Day) (Year)7-AGE, 52 yrs., 1 mos., 14 ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Foreman
(b) General nature of industry, business, or establishment in which employed (or employer), Ship-yards9-BIRTHPLACE, (State or Country), Chicago, Ill.10-NAME OF FATHER, Edwin Beck11-BIRTHPLACE OF FATHER (State or Country) Chicago Ill.12-MAIDEN NAME OF MOTHER Mary -13-BIRTHPLACE OF MOTHER (State or Country), Chicago -

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Beck(Address) 2234 Eastern Ave

15-APR 26 1920 ROBERT B. KAUTER

Filed, 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 23, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 21, 1920, to April 23, 1920, that I saw him live on April 23, 1920, and that death occurred, on the date stated above, at 11:30 p.
The CAUSE OF DEATH* was as follows:Bronchial AsthmaCONTRIBUTORY (Secondary) Cardiac Hypertrophy
(Duration) 6 yrs., 6 mos., 6 ds.(Signed) Edwin Beck M. D.
4/25/20 (Address) 408 S. Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, 14 yrs., 1 mos., 14 ds. In the State 14 yrs., 1 mos., 14 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, April 26, 192020-UNDERTAKER ADDRESS Remond & Sons 37 S. Calvert

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42588

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 3717 Saint An

St. 26 WARD)

FULL NAME

Cora H B Meekes

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 3717 Saint An

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

May

30

1914

(Month)

(Day)

(Year)

7-AGE,

4

36

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Nurse

(b) General nature of industry, business, or establishment in which employed (or employer).

OBS

9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

Baltimore

11-BIRTHPLACE OF FATHER
(State or Country),

Cda + Mary

12-MAIDEN NAME OF MOTHER

Cora H Meekes

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Cora H Meekes

(Address)

3717 Saint An

15-

FRI

APR 26 1920

101

ROBERT B. LEATHER

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 25, 1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said... (Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteric

(Duration).... yrs.... mos.... ds.

CONTRIBUTORY
(Secondary)

(Duration).... yrs.... mos.... ds.

(Signed) Phyllis M. D.

(Coroner.)

April 26, 1920 (Address) 1610 E. 7th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs.... mos.... ds. In the State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Mount Carmel

April 27, 1920

20-UNDERTAKER

ADDRESS

J. Sander Son

1710 West St.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D42589

D42589

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2127, Cambridge ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Stanislaw Sobotka

(a) RESIDENCE. NO.

2127, Cambridge ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Chieci

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Karol Sobotka

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Mary Kocum

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Stanislaw Sobotka 2127 Cambridge

15

Filed

APR 26 1920

ROBERT A. BRANTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 25 1920, to April 26 1920,

that I last saw him alive on April 26 1920,

and that death occurred, on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Aetalectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. K. M. D.

(Address) 801 M. K. M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

206 Kocum

4/26 1920

20 UNDERTAKER

M. Galkowski

ADDRESS

1618 Eastern Ave

D42590

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto. Gen. Hosp. 120 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Martha Judith Montague(Residence in Baltimore: No. 78 residence in Baltimore St.; X yrs., X mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, Single
 MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, January 9, 1836
 (Month) (Day) (Year)

7-AGE, 84 yrs., 3 mos., 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Virginia

10-NAME OF FATHER, Daniel M. Montague
 11-BIRTHPLACE OF FATHER (State or Country), Virginia
 12-MAIDEN NAME OF MOTHER, Mary McCallahan
 13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....
 (Address).....

15-Robert B. Foster
 Filed APR 26 1920 ROBERT B. FOSTER
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 26, 1920
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 25 1920, to April 26 1920, that I saw her alive on 191, and that death occurred, on the date stated above, at 6:30 a.m. The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
 (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY Uraemia
 (Secondary) (Duration)..... yrs..... mos..... ds.

(Signed) Witherby York M. D.
April 26, 1920 (Address) 1213 Eight St. - Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Christiansburg, Va. DATE OF BURIAL, April 26, 1920

20-UNDERTAKER, George Smith ADDRESS

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42591

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH USA General Hospital No.2

CITY OF BALTIMORE: (No. Fort McHenry, Md. ST.; WARD)

2-FULL NAME John Jolly, Pvt. Co. A. R.U. 321 M.T.C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence ~~1624 Park Ave., St. Louis, Mo.~~ St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male	4-COLOR OR RACE, White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)
6-DATE OF BIRTH, Unknown (Month) (Day) (Year)		
7-AGE, 23 yrs. mos. ds.		If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work, Soldier in (b) General nature of industry, business, or establishment in which employed (or employer), US Army		
9-BIRTHPLACE, (State or Country), Mo.		

PARENTS.	10-NAME OF FATHER, Unknown
	11-BIRTHPLACE OF FATHER (State or Country), Unknown
	12-NAME OF MOTHER Mrs. Sarah Jolly 1624 Park Ave. St. Louise, Mo.
	13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- **APR 26 1920**
 Filed.....
 Robert E. Krauter
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,
April 24, 1920
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
April 17, 1920 to **April 24, 1920**
 that I saw him alive on **April 24, 1920**
 and that death occurred, on the date stated above, at **6:45 A.m.**

The CAUSE OF DEATH* was as follows:

Meningitis- Pneumococcus.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) **James A. Wilson, Major, U.C.**
Apr. 24, 1920 (Address) **Ft. McHenry, Md.**

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42592

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *7th* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *Parkway Hill, Baltimore, Md.* ST. *1st* WARD. *Akron Ohio*

(Usual place of abode)

Length of residence in city or town where death occurred *1 mo 20 days*

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *T*6 DATE OF BIRTH (month, day, and year) *June 16 - 1872*7 AGE Years *47* Months *11* Days *9* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *000*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Mass.* (State or country)10 NAME OF FATHER *Alanson Wox.*11 BIRTHPLACE OF FATHER (city or town) *Illinois* (State or country)12 MAIDEN NAME OF MOTHER *Etta Lane*13 BIRTHPLACE OF MOTHER (city or town) *New York* (State or country)

14

Informant (Address) *J. H. H. Records*

15

APR 26 1920

ROBERT B. LEAUTER Registrar

Burial Permit 0102

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 25* 19*20*17 I HEREBY CERTIFY, That I attended deceased from *March 5th* 1920, to *April 25* 1920, that I last saw her alive on *April 25* 1920, and that death occurred, on the date stated above, at *8:12 P. m.*

The CAUSE OF DEATH* was as follows:

*Permeous Anaemia*CONTRIBUTORY (Secondary) *Combined Sclerosis* (duration) *4* yrs. mos. ds. (duration) *2* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Wm S. Tillet* M. D.4/26, 1920 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Akron Ohio*DATE OF BURIAL *April 26 1920*20 UNDERTAKER *Henry Jenkins, South St. College*

CAUSE OF DEATH IN PARTIALITY OF DEATH CERTIFICATE IS VERY IMPORTANT. See instructions on back of certificates.

D42593

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 337 So. Robinson ST.; 1 WARD)

2-FULL NAME

(Residence in Baltimore: No. 337 So. Robinson St.; 1 yrs., 6 mos., 8 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, Widow, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Oct 15, 1838
(Month) (Day) (Year)

7-AGE, 81 yrs., 6 mos., 8 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, At home
(b) General nature of industry, business, or establishment in which employed (or employer), 000

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, August Deems
11-BIRTHPLACE OF FATHER, (State or Country), Germany
12-MAIDEN NAME OF MOTHER, Not known
13-BIRTHPLACE OF MOTHER, (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Berl(Address) 337 S. Robinson

15-

Robert P. Harrison,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 24, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1913 to Apr. 24 1920, that I saw her alive on Apr. 24 1920, and that death occurred, on the date stated above, at 9:30 P. m. The CAUSE OF DEATH* was as follows:

arterio Sclerosis resulting in cerebral hemorrhage

(Duration) 10 yrs., 10 mos., 10 ds.
CONTRIBUTORY Fell on stairs 4/24/20
(Secondary)

(Duration) 10 yrs., 10 mos., 10 ds.
(Signed) Philip S. Fowler M. D.
4/25/20, 1920 (Address) 1432 William St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 10 yrs., 10 mos., 10 ds. In the State 10 yrs., 10 mos., 10 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Inf. Carmel

DATE OF BURIAL,

April 27 1920

20-UNDERTAKER

Jirkler & JirklerADDRESS 1739Eager

APR 26 1920

D42594

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42594

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 Sharp St. ST.: 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel E. Gulcherist(a) RESIDENCE. No. 1004 Sharp ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Sept. 5 1916

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.3 yrs. 7 mos. 20 ds.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md10 NAME OF FATHER John Gulcherist

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md12 MAIDEN NAME OF MOTHER Mabel Spontin13 BIRTHPLACE OF MOTHER (city or town) (State or country) M. Va

14

Informant (Address) Mr John Gulcherist
1004 Sharp St

15

Filed 1920Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1920

17

I HEREBY CERTIFY, That I attended deceased from April 23 1920, to April 25 1920, that I last saw her alive on April 20 1920, and that death occurred, on the date stated above, at 80 m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not knownDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. Harrison, M. D.Address 530 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Olivet CemeteryApril 26 1920

20 UNDERTAKER

Joseph B. Cook

ADDRESS

1003 N. Balto
Spur

CAUSE OF DEATH is very important. See instructions on back of certificates.

D42595

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 D42595
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 N Pine ST.; 17 WARD)

2-FULL NAME

(Residence in Baltimore: No. 412 N. Pine St.; yrs., mos. 4 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>7</u>	4-COLOR OR RACE, <u>Negro</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, <u>April 20, 1920</u> (Month) (Day) (Year)		
7-AGE,yrs.....mos.....ds.		If LESS than 1 day,hrs. or.....min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer).....		
9-BIRTHPLACE, (State or Country), <u>Balti City</u>		
PARENTS.	10-NAME OF FATHER, <u>George Burgess</u>	
	11-BIRTHPLACE OF FATHER (State or Country), <u>Va</u>	
	12-MAIDEN NAME OF MOTHER, <u>Virginia Kemner</u>	
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Va</u>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

April 24, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 20, 1920, to April 24, 1920, that I saw her alive on April 23, 1920, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)(Duration).....yrs.....mos.....ds.
(Signed) J. M. C. [Signature] M. D.
(Address) 412 N. Pine St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

HOPKINS HOSPITAL

....., 191...

20-UNDERTAKER

ADDRESS

J. M. C. [Signature] Health,

Wm. E. WOODALL

Important. See instructions on back of certificate.

APR 26 1920

City of Baltimore
D42596

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42596

CERTIFICATE OF DEATH.

PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE (No. 1071 Jenkins Alley ST. 11

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Sept. 24, 1920
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day,
7 hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

none

000

9-BIRTHPLACE, (State or Country),

Balto Md.

10-NAME OF FATHER,

Clarence Lewis

11-BIRTHPLACE OF FATHER (State or Country),

unknown

12-MAIDEN NAME OF MOTHER

Edith Underwood

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

Robert P. Harrison, REGISTRAR.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 24, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Failure of closure of valves of heart.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. E. Smith, M. D.
(Coroner)
Sept 25, 1920 (Address) 401 Light St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

Health,

ADDRESS

CAUSE OF DEATH in plain terms, if not in technical terms, on back of certificate. important. See instructions on back of certificate.

APR 26 1920

191. Registrar.

JOHNS HOPKINS HOSPITAL

191. Registrar.

APR 26 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42597

D42597

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert W. Thompson(Residence in Baltimore: No. 808 E. Pratt St. St.: ? yrs., ? mos., ? ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, 1859, 1
(Month) (Day) (Year)

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer), Unknown

9-BIRTHPLACE, (State or Country), New York City

PARENTS.
10-NAME OF FATHER, Isaac Thompson
11-BIRTHPLACE OF FATHER (State or Country), New York City
12-MAIDEN NAME OF MOTHER, Eliza Hall
13-BIRTHPLACE OF MOTHER (State or Country), New York City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Records(Address) New City Hospital

15-

APR 26 1920 Robert B. Harrison

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 21, 1920, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 2, 1919, to April 21, 1920, that I saw him alive on April 20, 1920, and that death occurred, on the date stated above, at 2:40 m. The CAUSE OF DEATH* was as follows: AM

Carcinoma Region Rt. Ear and Mandible
(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Severe hemorrhage from Carcinoma
(Duration) ? yrs. mos. ds.
(Signed) Frank T. Baker M. D.

April 21, 19120 Address) New City Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, ? yrs. mos. ds. In the State ? yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL DATE OF BURIAL, APR 26 192020-UNDERTAKER Health

Commissioner

important. See instructions on back of certificate.

D42598

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42598

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Spengler(a) RESIDENCE. NO. 1510 Fleet St.

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Unknown</u>
----------------------	---------------------------------	--

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 18 50

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
<u>70</u>				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) Germany
(State or country)10 NAME OF FATHER Andrew Spengler11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)12 MAIDEN NAME OF MOTHER Marie Kuhn13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14

Informant Hospital Records(Address) New City Hospital

15

Filled

Robert B. Harrison

Registrar

APR 26 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 22, 1920, to April 22, 1920.that I last saw him alive on April 22, 1920.and that death occurred, on the date stated above, at 9:25 P.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumoniaunknown (duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)Lung Abscess(duration) yrs. 13 mos. ds.18 Where was disease contracted
if not at place of death?unknownDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

no special test

(Signed)

J. J. Pessel

M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Apr. 23 1920 Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITAL

19

20 UNDERTAKER

ADDRESS

Carroll's Health,

APR 26 1920

D42599

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42599

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 W. Wolfe ST. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ruth Marie Siler

(a) RESIDENCE. NO.

13 W. WolfeST. 6 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child6 DATE OF BIRTH (month, day, and year) Sept. 7th 19177 AGE Years 2 Months 7 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) MD

10 NAME OF FATHER

Charles A. Siler11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) MD12 MAIDEN NAME OF MOTHER Marie L. Kahler13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country) MD

14

Informant (Address)

Charles A. Siler13 W. Wolfe St.ROBERT F. HARRISON,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24th 19 2017 I HEREBY CERTIFY, That I attended deceased from April 22, 1920, to April 25, 1920, that I last saw him alive on April 25, 1920, and that death occurred, on the date stated above, at 5 A .m.

The CAUSE OF DEATH* was as follows:

Heart FailureCONTRIBUTORY (Secondary) Brachy Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of noWas there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Harrison M. D. (Address) 16 V. Boly

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

ZION Cemetery, Baltimore, Md.April 27 19 20

20 UNDERTAKER

Lilly & Zeller

ADDRESS

403 S. Wolfe St.

CAUSE OF DEATH is very important. See instructions on back of certificate.

D42600

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42600

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *26* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Annie Mansolf*(a) RESIDENCE. NO. *1319 S. Clinton St.* ST. *26* WARD. *26*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *20* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *W.* 5 Single, ~~Married~~, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

~~Married~~
(or) ~~Widowed~~*A. Mansolf*6 DATE OF BIRTH (month, day, and year) *April 1896*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
24 — — —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Blue Island, Connecticut*10 NAME OF FATHER *Wm. Ready*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ansonia, Connecticut*12 MAIDEN NAME OF MOTHER *Sarah Brown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

14

Informant (Address)

*Mrs. Sarah Brown, 1319 S. Clinton St.**Robert P. Harrison,*

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 25 1920*

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 14 1920, to *Apr. 25 1920*.that I last saw ~~her~~ alive on *Apr. 20 1920*.and that death occurred, on the date stated above, at *6:30 P.* m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia(duration) — yrs. — mos. *9* ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

J. J. Ridgely

M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Carmel Cem.

DATE OF BURIAL

April 28 1920

20 UNDERTAKER

Lilly and Fisher.

ADDRESS

403 S. Myrtle

CAUSE OF DEATH is very important. See instructions on back of certificates.

APR 26 1920

D42601

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42601

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST. 10 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 1224 E Eager ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

50 yrs.

mos.

8 ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

widower

5a If married, widowed or divorced HUSBAND of (or WIFE of)

the late Minnie Hamelin

6 DATE OF BIRTH (month, day, and year)

April 16 1870

7 AGE

48

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundryman

(b) General nature of industry, business, or establishment in which employed (or employer)

041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto.

10 NAME OF FATHER

Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Not Known

12 MAIDEN NAME OF MOTHER

Mrs. Kim

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not Known

14

Informant (Address)

Mrs. Edward Hamelin
1416 N. Chester St.

Robert F. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1920

17

I HEREBY CERTIFY, That I attended deceased from April 23 1920, to April 24 1920,

that I last saw him alive on April 24 1920

and that death occurred, on the date stated above, at 9:30 A. M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

Chronic Interstitial Nephritis indefinitely

18 Where was disease contracted

If not at place of death?

unknown

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis? clinical signs & symptoms

(Signed) Daniel Miller, M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cemetery

Apr. 27 1920

20 UNDERTAKER

Henry Ford (Su)

ADDRESS

301 E Eager

APR 26 1920

Burial Permit (Blank)

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42602

D42602

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *New City Hospital* ST. *5* WARD)

2-FULL NAME

Olivia Robinson

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

264 N. Exeter

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1876

7 AGE

44

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

*Hospital Records
New City Hosp.*

15

Filed

APR 26 1920

19 Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-24 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

4-20, 19 *20*, to *4-24*, 19 *20*,that I last saw her alive on *4-24*, 19 *20*,and that death occurred, on the date stated above, at *2:50 P. M.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic Diffuse Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*Unknown*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

Urine tests

(Signed)

J. P. Carroll

M. D.

4-24-20 Address

Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Secretary Dockyard C. Md**Apr. 26 1920*

20 UNDERTAKER

Henry Street Law

ADDRESS

1301 E. Eager

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42603

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Church Home and Infirmary.*
 CITY OF BALTIMORE: (No. *26* *N. Broadway* ST.; *15* WARD)
 2-FULL NAME *Mrs. Ida T. Schuster*
 (Residence in Baltimore: No. *1614 W. North Ave* St.; *42* yrs., *6* mos. *13* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female*
 4-COLOR OR RACE. *White*
 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
 6-DATE OF BIRTH. *October 11, 1877*
 (Month) (Day) (Year)

7-AGE. *42* yrs., *6* mos., *13* ds.
 If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *(none) 1037*
 (b) General nature of industry, business, or establishment in which employed (or employer). *(none)*

9-BIRTHPLACE. (State or Country). *Baltimore Md*

10-NAME OF FATHER. *John H. Thieme*

11-BIRTHPLACE OF FATHER (State or Country). *Germany*

12-MAIDEN NAME OF MOTHER. *Anna Cecilia Meyer*

13-BIRTHPLACE OF MOTHER (State or Country). *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Schuster (husband)*
 (Address) *1614 W. North Ave*

15-

Robert P. Harrison
 Registrar.

Marial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *April 24, 1920*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 4* 1920, to *April 24* 1920, that I saw her alive on *April 24* 1920, and that death occurred, on the date stated above, at *8:15 P.m.*

The CAUSE OF DEATH* was as follows:
Adeno Myomata uteri adherent to ovary (left) and Rctum
Sarcoma, (left) cystic ovary (left).
 (Duration).....yrs.....mos.....ds.

CONTRIBUTORY *Uremia (Post operation)*
 (Secondary)
 (Duration).....yrs.....mos.....ds.

(Signed) *Walter S. Anderson M.D.*
April 24, 1920 (Address) *O. H. & T.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *0* yrs. *0* mos. *24* ds. In the State *42* yrs. *6* mos. *13* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1614 W. North Ave*

19-PLACE OF BURIAL OR REMOVAL. *Lorraine Cemetery*

DATE OF BURIAL. *April 27, 1920*

UNDER-TAKER. *STERN & SOWEN COMPANY*
 (WILLIAM F. WOODEN, Successor)

ADDRESS *108 W. NORTH AVE.*

important. See instructions on back of certificate.

APR 26 1920

D42604

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42604

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No.

224 N. Gay

ST.

WARD)

2-FULL NAME

Howard A. Frey

(Residence in Baltimore: No.

224 N. Gay

St.

36

yrs.

mos.

ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Divorced

6-DATE OF BIRTH

March

15, 1883

(Month)

(Day)

(Year)

7-AGE

37

yrs.

1

mos.

8

ds.

If LESS than
1 day, hrs.
or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Bar tender

9 BIRTHPLACE
(State or country)

York Pa.

10 NAME OF FATHER

Howard Frey

11 BIRTHPLACE OF FATHER
(State or country)

York Pa.

12 MAIDEN NAME OF MOTHER

Daisy V. Morris

13 BIRTHPLACE OF MOTHER
(State or country)

York Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Daisy V. Hand

(Address)

224 N. Gay

15.

Robert P. Harrison,

APR 26 1920

191

Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

April

23, 1920

(Month)

(Day)

(Year)

17.

I HEREBY CERTIFY, That I attended deceased from

6 PM

191

9.

to.

23

April

1920

that I saw him alive on

23

April

1920

and that death occurred, on the date stated above, at 11:50 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) 1 yrs. 6 mos. ds

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

James S. Schaffer, M.D.

24 April, 1920 (Address) 1412 Leggett

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

Where was disease contracted,

if not at place of death?

Former or

usual residence

In the

State

yrs.

mos.

ds.

19-PLACE OF BURIAL OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

April 27, 1920

20-UNDERTAKER

William E. Schaffer

ADDRESS

1816 Monument

N.B.-Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42605

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42605

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 623 Glenwood Ave. ST.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellis J. Knox(a) RESIDENCE. NO. 623 Glenwood Ave. ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

(white)

5 Single, Married, Widowed, or Divorced (write the word)

child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

(child)(2)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

(child)

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

Ellis J. Knox

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Ida B. Mull

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto md

14

Informant (Address)

Ellis J. Knox
623 Glenwood AveRobert P. Harrison

Registrar

15

Date

APR 26 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr 23, 1920, to Apr. 26, 1920.that I last saw him alive on Apr. 25, 1920.and that death occurred, on the date stated above, at 5:15 A m.

The CAUSE OF DEATH* was as follows:

Blue baby. Bad heart action(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. H. Duncan, M. D., 19 (Address) 5706 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

mt. OlivetApril 27 1920

20 UNDERTAKER

William Cook

ADDRESS

502 E. North Ave

D42606

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42606

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 W. 21st ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane D. Huff(Residence in Baltimore: No. 16 W. 21st St.; 45 yrs., X mos., X ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F4-COLOR OR RACE, W.5-SINGLE, widow
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, Sept 20, 1850

(Month)

(Day)

(Year)

7-AGE, 69 yrs., 7 mos., 5 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, none

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), York Co Pa.10-NAME OF FATHER, unknown11-BIRTHPLACE OF FATHER (State or Country), unknown12-MAIDEN NAME OF MOTHER, unknown13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick H. Statler(Address) 16 W. 21st St.

15-

Robert P. Harrison,

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 25, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1919, to April 25, 1920, that I saw her alive on April 25, 1920, and that death occurred, on the date stated above, at 6:50 P. m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) Cerebral Hemorrhage(Signed) John J. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, ... yrs., ... mos., ... ds. In the State, ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Prospect Hill Cemetery, York Pa.DATE OF BURIAL, April 26, 192020-UNDERTAKER George J. ...ADDRESS ...

D42607

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42607

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST. 12 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 40 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and from the evidence obtained by autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

APR 26 1920

191

Burial Permit Clerk Registrar.

D42608

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42608

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1003 David Hill

St. 11

WARD)

FULL NAME

Susie Simms

(Residence in Baltimore: No. 1003 David Hill

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX,

Female

COLOR OR RACE,

Caucasian

5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

DATE OF BIRTH,

Unknown

1868

(Month)

(Day)

(Year)

AGE,

✓✓

If LESS than 1 day,

hrs. or min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

maid

070

BIRTHPLACE,
(State or Country),

Ireland

NAME OF FATHER,

Edward Simms

BIRTHPLACE OF FATHER
(State or Country),

Ireland

MAIDEN NAME OF MOTHER

Annella Davis

BIRTHPLACE OF MOTHER
(State or Country),

Ireland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Geo. J. Simms

(Address)

1507 Devereux St.

15-

APR 26 1920

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

DATE OF DEATH,

Apr. 24, 1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to death

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. E. Simms M. D.

(Coroner.)

Apr. 24, 1920

(Address) 910 Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn Cem.

DATE OF BURIAL,

Apr. 27, 1920

20-UNDERTAKER

Samuel Hensley

ADDRESS

5787 Biddle St.

D42609

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42609

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *118 Cedar Av.* ST. *27* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *118 Cedar Av.* ST.WARD. *Harford Co. Md.*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. *4*

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Wht

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

E. S. Tucker

6 DATE OF BIRTH (month, day, and year)

Aug. 21/1869

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*50**8**5*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Harford Co. Md.

10 NAME OF FATHER

Lewis Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Miss Grafton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

E. S. Tucker
*118 Cedar Av.**Robert P. Harrison,*

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 26th 1920*

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 5, 19*20*, to *Apr. 26*, 19*20*,that I last saw her alive on *Apr. 25*, 19*20*,and that death occurred, on the date stated above, at *4:30 a* m.

The CAUSE OF DEATH* was as follows:

Nephritis Brights disease(duration) yrs. *6* mos. ds.

CONTRIBUTORY (Secondary)

Dropsy & gradual Marking(duration) yrs. *3* mos. ds.

18 Where was disease contracted if not at place of death?

*Milton St. Av.*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

Urinalysis

(Signed)

B. S. Baker

M. D.

, 19

(Address)

1005 W. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Forest Hill Harford Co. Md.**Apr 28 1920*

20 UNDERTAKER

ADDRESS

Liston P. Fosselbaugh 26205 Paul St

TION is very important. See instructions on back of certificates.

APR 26 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42610

CERTIFICATE OF DEATH.

79 D42610
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1944 Smith Hill Ave. ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Levi H. Cornish(Residence in Baltimore: No. 1944 Smith Hill Ave. St. 14 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE

colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH.

July 5
(Month)Friday, 1890
(Day) (Year)

7-AGE.

29 yrs. 9 mos. 7 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Maryland10-NAME OF FATHER, Levi H. Cornish11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.12-MAIDEN NAME OF MOTHER Hallie Van Lear13-BIRTHPLACE OF MOTHER (State or Country), Hagerstown Md.

14-THIS ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hallie V. Cornish(Address) 1944 Smith Hill Ave.

15-

APR 27 1920

ROBERT E. KAUTER

BURIAL PERMIT REQUIRED

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr. 24, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr. 2, 1920, to Apr. 24, 1920,that I saw him alive on Apr. 24, 1920,and that death occurred, on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis

.....

..... (Duration) yrs. 2 mos. — ds.CONTRIBUTORY (Secondary) Pulmonary..... (Duration) yrs. 10 mos. — ds.(Signed) W. J. Carr, M. D.Apr. 26, 1920 (Address) 515 N. Market St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Central Cem.

DATE OF BURIAL,

4/27/20

20-UNDERTAKER

Edw. B. Pyle 102 E. Mulberry

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42611

CERTIFICATE OF DEATH,

81

D42611

1-PLACE OF DEATH

Little Sisters of the Poor

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Bridget M. Cann

(Residence in Baltimore: No.

Little Sisters of the Poor

St.; 50 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female	4-COLOR OR RACE. White	5-STATUS. MARRIED, married WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH. Unknown, 1 (Month) (Day) (Year)		
7-AGE. out 75 yrs., 0 mos., 0 ds.		8-IF LESS than 1 day. 0 hrs. or min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work. None 037 (b) General nature of industry, business, or establishment in which employed (or employer).		

9-BIRTHPLACE.
(State or Country),

Ireland

10-NAME OF FATHER,

James

11-BIRTHPLACE OF FATHER
(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Rose Rice

13-BIRTHPLACE OF MOTHER
(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Sister Benedict

(Address)

Little Sisters of the Poor

APR 27 1920

Filed.....

191

ROBERT F. KRAUTER

Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(April) 25, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

No record 191, to 191

that I saw her alive on April 25, 1920,

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

F. H. Warner

M. D.

April 26, 1920 (Address) 1133 Valley Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Cathedral Cemetery

DATE OF BURIAL,

April 26, 1920

20-UNDERTAKER

James F. Dignan

ADDRESS

1000 S Paca St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42612

CERTIFICATE OF DEATH.

REGISTERED NO. C

D42612

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *925 S. Poca* St.; *21* WARD)2-FULL NAME *Gordon H. Griseudaffer*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *925 S. Poca* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*4-COLOR OR RACE. *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH. *May 3* 1919

(Month)

(Day)

(Year)

7-AGE. *11* yrs. *11* mos. *23* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer) *800*9-BIRTHPLACE, (State or Country), *Balto Md.*10-NAME OF FATHER, *Geo H. Griseudaffer*11-BIRTHPLACE OF FATHER (State or Country), *Balto Md.*12-MAIDEN NAME OF MOTHER *Margaret Stanford*13-BIRTHPLACE OF MOTHER (State or Country), *Balto Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Grattner*(Address) *925 S. Poca St.*

15-APR 27 1920

Filed....., 191.....

ROBERT B. KAUTER

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *April* 26, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Apr. 20* 1920 to *Apr. 26* 1920,that I saw him alive on *Apr. 26* 1920,and that death occurred, on the date stated above, at *7 P.* m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) *Pneumonia*(Signed) *Herbert Blake*(Address) *114 N. E. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Goulden Park*DATE OF BURIAL, *Apr. 27* 192020-UNDERTAKER *James Dignan*ADDRESS *1000 S. Poca St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42613

CERTIFICATE OF DEATH.

28

D42613

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian Thomas(a) RESIDENCE. NO. 2139 E. Oliver St. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

MaleWhiteSeparated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown6 DATE OF BIRTH (month, day, and year) 1864

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

John Thomas

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margaret Thomas

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant Hospital Records
(Address) M.T.H.

15

Filed

19

APR 27 1920

ROBERT R. HAUTER
RegistrarSerial 1111 1111

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug. 8th, 1919, to April 26, 1920,that I last saw him alive on April 26, 1920,and that death occurred, on the date stated above, at 12.15 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

UnknownDid an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? TB in Sputum

(Signed)

George R. Wilkinson, M. D.
4/26/20 (Address) Municipal TBC Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Int. CanalApril 31, 1920

20 UNDERTAKER

William Cook

ADDRESS

302 E. PrattAve.

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42614

CERTIFICATE OF DEATH.

79 D42614

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2201 Jefferson St. ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Abraham Etkins

(a) RESIDENCE. NO.

2201 Jefferson St. ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown 1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

70

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

J. Lewis 1411 E. 13th St.

15

Date

APR 27 1920ROBERT E. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-27 1920

17

HEREBY CERTIFY, That I attended deceased from April 15th, 1920, to April 26, 1920, that I last saw him alive on April 26, 1920, and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Myocarditis

CONTRIBUTORY (Secondary)

Dilated heart

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Maurice Chudevick, M. D., 19 (Address) 2328 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Green Mt. Cemetery4-27 1920

20 UNDERTAKER

ADDRESS

Jack Lewis1411 E. 13th St.

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42615

CERTIFICATE OF DEATH.

113 D42615

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mount Hope Retnat* ST.: *28* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Emma Schwin

(a) RESIDENCE. NO.

718 McHury

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Peter Schwin

6 DATE OF BIRTH (month, day, and year)

Jan 12 1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

William Hess

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md.

12 MAIDEN NAME OF MOTHER

Annie Carl (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Penn.

14

Informant (Address)

*Records of Mt Hope Retnat
Mt Hope Md.*

15

APR 27 1920

ROBERT E. KRATZER

Bacial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 26 1920*

17

I HEREBY CERTIFY, That I attended deceased from

April 24 189, to *April 26 1920*,that I last saw her alive on *Apr-26 1919*,and that death occurred, on the date stated above, at *11.30 P.* m.

The CAUSE OF DEATH* was as follows:

*Chr. Hepatitis**abt*(duration) *1* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary)

*Dementia Senile**abt*(duration) *1* yrs. *1* mos. *0* ds.

18 Where was disease contracted

if not at place of death?

Baltimore

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed) *Frank J. Flannery* M. D.Address) *Mt Hope Retnat*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Landon Park Cem**April 27 1920*

20 UNDERTAKER

*Joseph B. Cook*ADDRESS *1003 N. Balto St.*

TION is very important. See instructions on back of certificates.

D42616

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42616

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 N. Washington ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 807 N. Washington ST. 7 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Sweeney6 DATE OF BIRTH (month, day, and year) Aug 21 - 18637 AGE Years 56 Months 10 Days 06 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sergeant Police Dept.(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland
(State or country)10 NAME OF FATHER Patrick Sweeney11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)12 MAIDEN NAME OF MOTHER Bath Kelly13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)14 Informant Mary A. Sweeney
(Address) 807 N. Washington St.15 APR 27 1920 ROBERT E. LEAUFER Registrar
Burial Permit GREEN

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 19 2017 I HEREBY CERTIFY, That I attended deceased from April 1, 19 19, to April 25, 19 20.That I last saw him alive on April 25, 19 20.and that death occurred, on the date stated above, at 2.30 P. m.The CAUSE OF DEATH* was as follows:
Coronary of R. etumCONTRIBUTORY (Secondary) Coronary of R. etum (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10 mo. ago.Was there an autopsy? noWhat test confirmed diagnosis? Sup.otomy(Signed) William A. R. etum, M. D.(Address) 801 N. Wood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New bath dead20 UNDERTAKER L. A. Moran

DATE OF BURIAL

4/28 19 20ADDRESS 7000E. B. etum

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42617

CERTIFICATE OF DEATH.

167 D42617
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 S. Linsellwood ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 305 S. Linsellwood St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)6-DATE OF BIRTH. Jan. 19, 1915
(Month) (Day) (Year)7-AGE, 5 yrs., 3 mos., 5 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer) None9-BIRTHPLACE, (State or Country), Baer10-NAME OF FATHER, Frank Adams11-BIRTHPLACE OF FATHER (State or Country), Austria12-MAIDEN NAME OF MOTHER Ida K. Wahler13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Adams(Address) 305 S. Linsellwood

15-

Filed APR 27 1920 191. ROBERT E. LEAUTEK
Burial Forest Home

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 24, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 23, 1920, to April 24, 1920, that I saw her alive on April 24, 1920, and that death occurred, on the date stated above, at 12:45 PM. The CAUSE OF DEATH* was as follows:
Burns - from fire.
(Duration) 24 hrs.CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.(Signed) Howard W. Jones M. D.April 26, 1920 (Address) Washington

*State the DISEASE CAUSING DEATH, or, in deaths from violent causes, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.Where was disease contracted, if not at place of death? Former or usual residence 19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, April 27, 192020-UNDERTAKER C. W. Dill ADDRESS 3109 Fredk. Ave.

D42618

HEALTH DEPARTMENT - CITY OF BALTIMORE D42618

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD)2-FULL NAME *Samuel Munday*(a) RESIDENCE. NO. *Essexville Md*

(Usual place of abode)

Length of residence in city or town where death occurred *unknown* yrs. mos. ds.ST. *4* WARD.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Separate*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1891*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Pipe fitter 059*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Na.*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*

14

Informant (Address) *Univ. Hosp. Records*

15

APR 27 1920

ROBERT B. LEAUTE

Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/25* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from *3/25* 19*20*, to *4/25* 19*20*.that I last saw him alive on *4/25* 19*20*.and that death occurred, on the date stated above, at *3.30 a* m.

The CAUSE OF DEATH* was as follows:

*Empyema of Gall Bladder*CONTRIBUTORY (Secondary) *General Sepsis* (duration) yrs. mos. *14* ds.18 Where was disease contracted (duration) yrs. mos. *7* ds.

If not at place of death?

Did an operation precede death? *Yes* Date of *April*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Wm. Steen*4/25 1920 (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Essexville Md April 28 1920

20 UNDERTAKER

Jas R. Weet - Essexville

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42619

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 N. Washington St. 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 118 N. Washington St.; 35 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F

4-COLOR OR RACE,

W

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Widow

6-DATE OF BIRTH,

April (Month) 4 (Day), 1862 (Year)

7-AGE,

60 yrs., 27 mos., ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None0009-BIRTHPLACE,
(State or Country),Fredrick County MD.

PARENTS.

10-NAME OF FATHER,

John Schwarber11-BIRTHPLACE OF FATHER
(State or Country),Fredrick County MD

12-MAIDEN NAME OF MOTHER

Mary Fogel13-BIRTHPLACE OF MOTHER
(State or Country),Fredrick County MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. G. Meyer(Address) 118 N. W. Washington

15-

APR 27 1920

Filed

191

ROBERT E. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 23, 1920, to April 25, 1920,that I saw her alive on April 25, 1920,and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) 3 yrs., 3 mos., 3 ds.CONTRIBUTORY
(Secondary)Cerebral Hemorrhage(Duration) 3 yrs., 3 mos., 3 ds.(Signed) Geo. Heller M. D.475 (Address) 1937

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Ladiesburg Fredrick County MD April 27 1920

20-UNDERTAKER

ADDRESS

Wendell Pyffel & Son 378 N. W. 1

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42620

D42620

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 875 Clifford ST. 21 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Blaxter(Residence in Baltimore: No. 875 Clifford St. life yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Color

5-SINGLE,

MARRIED, Married

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

Dec.131898

(Month)

(Day)

(Year)

7-AGE,

21413ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country).

Balto. Md

10-NAME OF FATHER,

Wm. O. Davis

11-BIRTHPLACE OF FATHER (State or Country).

Balto. Md

12-MAIDEN NAME OF MOTHER

Jucy Armand

13-BIRTHPLACE OF MOTHER (State or Country).

Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Davis(Address) 875 Clifford St

15-

Filed

APR 27 1920

ROBERT B. TRAUTER

BURIAL & REMOVAL REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April261920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr 21 1920, to April 26 1920,that I saw her alive on Apr 21 1920,and that death occurred, on the date stated above, at 12:08 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 2 yrs., 0 mos., 0 ds.

CONTRIBUTORY

(Secondary)

(Duration) 0 yrs., 0 mos., 0 ds.(Signed) Wm. O. Davis

M. D.

Apr 26 1920 (Address) 875 Clifford St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Not Auburn Cem.

DATE OF BURIAL.

Apr 28 1920

20-UNDERTAKER

W. Doyle

ADDRESS

15 E. Lee St.

1042621

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

1042621

1042631

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

(Residence in Baltimore: No.

St.; 3 yrs. 4 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH

AGE

11 LESS than
1 day, hrs.
or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)BIRTHPLACE
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

APR 27 1920

ROBERT A. KRAUTER

Burial in: REGISTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 26, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

April 25, 1920, to, April 26, 1920

that I saw her alive on April 26, 1920

and that death occurred, on the date stated above, at 4:00 P.m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(Duration) yrs. mos. 8 ds.

Contributory
(SECONDARY)Mongolian idiosyncrasy
(Duration) 3 yrs. 4 mos. 3 ds.

(Signed)

April 27, 1920 (Address) Sydenham Hosp.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death? at home

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Hehren Herrington

20 UNDERTAKER

Jack Lewis

DATE OF BURIAL

4-27-20

ADDRESS

1411 E. Baltimore

N. B.-Every item on this certificate is very important. See instructions on back of certificate.

D42622

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42622

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1661 Clifton ST.; 8 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1661 Clifton St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

April 23, 1920
(Month) (Day) (Year)

7-AGE,

yrs. 3 mos. 3 ds.

If LESS than 1 day,
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country).

Baltimore Md

10-NAME OF FATHER,

John Saffery

11-BIRTHPLACE OF FATHER
(State or Country).

Providence R.I.

12-MAIDEN NAME OF MOTHER

Rosa Johnson

13-BIRTHPLACE OF MOTHER
(State or Country).

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jessie E. J. Lucas(Address) 1661 Clifton Ave.

15-

APR 27 1920 ROBERT B. KRAUTER

Filed 191 Social Permit CLAY

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 26, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 25, 1920, to April 25, 1920, that I saw her alive on April 24, 1920, and that death occurred, on the date stated above, at 5:20 m. The CAUSE OF DEATH* was as follows:

Pneumonia (6 months)

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. Possible illness in February

(Signed) R. B. Carman M. D.April 26, 1920 (Address) 1701 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

St. Vincent's

DATE OF BURIAL.

April 27, 1920

ADDRESS

20-UNDERTAKER

Leo G. Cook North Ave.

D42623

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42623

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 Haynard an, ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Joseph Phelp McFerr

(a) RESIDENCE. NO. 315 Haynard an, ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Mary Adelaide McFerr

6 DATE OF BIRTH (month, day, and year) April 14-1875

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

45

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Pattern Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

John R. Livingston

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Joseph P. McFerr

11 BIRTHPLACE OF FATHER (city or town)

England

12 MAIDEN NAME OF MOTHER

Kate E. McCauley

13 BIRTHPLACE OF MOTHER (city or town)

Pa.

14

Informant
(Address)N. O. E. Employed
315 Haynard an

15

APR 27 1920

ROBERT A. LESTER

Bacial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25- 1920

17

I HEREBY CERTIFY, That I attended deceased from

Jan., 1919, to April, 1920

that I last saw him alive on April 24, 1920

and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Heart Disease

(duration) yrs. 14 mos. ds.

CONTRIBUTORY
(Secondary)

Influenza

(duration) yrs. mos. 19 ds.

18 Where was disease contracted

if not at place of death?

Baltimore Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed)

H. K. Gough, M. D.

426 120 (Address)

117 W. Sanson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Herald Ridge. Apr 28 1920

20 UNDERTAKER

ADDRESS

Wendover. 5028 North Ave

D42624

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42624

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

Mercy Hospital

ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs. Mary Cunningham

(a) RESIDENCE. NO.

1565 Highland

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 45 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

James T. Cunningham

6 DATE OF BIRTH (month, day, and year)

April 26/1860

7 AGE

60

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

Sawyer

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Germany

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Germany

14

Informant
(Address)

Agnes Wautler

1572 Highland St.

APR 27 1920

ROBERT H. TRAUBER

Baptist Minister

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4/27

1920

17

I HEREBY CERTIFY, That I attended deceased from

April 23, 1920, to April 27, 1920,

that I last saw her alive on April 26, 1920,

and that death occurred, on the date stated above, at 2:55 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Intestinal obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes. Date of

April 23/20

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jonathan B. Peterson, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Reisterstown M. S.

April 28 1920

20 UNDERTAKER

ADDRESS

Wm. L. L.

502 E. Natl Ave

TION is very important. See instructions on back of certificates.

D42625

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42625

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Antony Ave near Franklin*)

2-FULL NAME

(Residence in Baltimore: No. *Antony Ave near Franklin*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

married

6-DATE OF BIRTH.

Dec. 13, 1889
(Month) (Day) (Year)

7-AGE.

*30 yrs. 4 mos. 12 ds.*If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer).*Business*
*026*9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

APR 27 1920

ROBERT B. KAUTER

BALTIMORE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Apr. 25, 1920
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Apr. 16* 19*20*, to *Apr. 25* 19*20*, that I saw him live on *Apr. 22* 19*20*, and that death occurred, on the date stated above, at *12:30* m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
(Duration)....yrs....mos....ds.CONTRIBUTORY
(Secondary)(Signed) *P. E. Ryan* M. D.
4-26, 1920 (Address) *153 W. 1st St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer Cemetery *April 28, 1920*

20-UNDERTAKER

ADDRESS

Wm. Lassabum & Sons *Baltimore Md.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D42626

D42626

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *New City Hospital* ST.: *5* WARD)2-FULL NAME *Ella Bennett*(a) RESIDENCE. NO. *149 Rogers*

(Usual place of abode)

Length of residence in city or town where death occurred *20* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

unknown

6 DATE OF BIRTH (month, day, and year)

18 70

7 AGE

50

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Eastern Shore

(State or country)

10 NAME OF FATHER

Robert Small

11 BIRTHPLACE OF FATHER (city or town)

Eastern Shore Md.

(State or country)

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

unknown

(State or country)

14

Informant (Address)

*Hospital Records
New City Hospital*

15

APR 27 1920

ROBERT H. ELLIOTT Registrar

Baptist Church Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-24 1920*17 I HEREBY CERTIFY, That I attended deceased from *4-17 1920* to *4-24 1920* that I last saw her alive on *4-24 1920* and that death occurred, on the date stated above, at *3:50 P. m.*

The CAUSE OF DEATH* was as follows:

*Chronic Diffuse Nephritis*CONTRIBUTORY (Secondary) *uremia* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *urine tests* M. D.

(Signed)

J. P. Peral 9-24 1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Bellview Cem

20 UNDERTAKER

Mrs R A Elliott

DATE OF BURIAL

*Apr 27 1920*ADDRESS *1725**Ashland**Ale*

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42627

D42627

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bath Bldg. Gent Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

1213 Light

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mr. William H. Camper

(Residence in Baltimore: No.

413 E Fort Ave

St.;

22

yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

May 19, 1841

7-AGE,

78 yrs., 11 mos., 6 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired farmer

9-BIRTHPLACE, (State or Country),

Haverhill Co.

10-NAME OF FATHER,

Harry Camper

11-BIRTHPLACE OF FATHER (State or Country),

England

12-MAIDEN NAME OF MOTHER

Mary Bovey

13-BIRTHPLACE OF MOTHER (State or Country),

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Laura D. Carroll

(Address)

413 E Fort Ave

15-

APR 27 1920

ROBERT R. KRAUTER

Special Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

4-25-1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

4-16-1920, to 4-25-1920,

that I saw him alive on 4-25-1920,

and that death occurred, on the date stated above, at 8.15 p.m.

The CAUSE OF DEATH* was as follows:

1- Chronic nephritis (interstitial)

2- prostatic hypertrophy

.....

..... (Duration) 2 yrs., 2 mos., 2 ds.

CONTRIBUTORY (Secondary)

..... (Duration) 2 yrs., 2 mos., 2 ds.

(Signed) R. R. Reynold M. D.

4-25-1920 (Address) 1213 Light St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

4/28/1920

20-UNDERTAKER

E J Fanning 1460 Battery Ave

D42628

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42628

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

339. *Elchester* St.

WARD) 12

2-FULL NAME

Chas. H. Schmette

(Residence in Baltimore: No.

339. *Elchester* St.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *12* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Oct 6, 1853
(Month) (Day) (Year)

7-AGE,

66
yrs. *6* mos. *20* ds.If LESS than 1 day,
...hrs. or ...mo.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*clerk*9-BIRTHPLACE,
(State or Country),*Ind.*

10-NAME OF FATHER,

*H. Schmette*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Margaret Hammett*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Flarence A. Schmette

(Address)

339. Elchester St.

15-

ROBERT B. KAUFER

APR 27 1920

191. *Registrar*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 26, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*
(Inquest, autopsy or inquest.)thereon and from the evidence obtained by said *inquest*
(Inquest, autopsy or inquest.)and that said deceased came to *death*
on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary
disease of heart
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *John Thomas* M.D.(Address) *7132 Roland Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*London Park Cemetery**April 27, 1920*

20-UNDERTAKER

ADDRESS

C. Schloman

CAUSE OF DEATH in plain terms, to time & place of death, to be filled in by the coroner. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST.: *5*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *1409 May St.* ST.: *12th*

(Usual place of abode)

WARD. *12th*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 19 1919*

7 AGE

Years *11*Months *4*Days *4*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Lucy Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant (Address)

Hospital Record J. H. H.

15

APR 27 1920

ROBERT B. KRAUTER Registrar

Baptist Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 23 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*March 15 1920 to April 23 1920.*that I last saw him alive on *April 23 1920.*and that death occurred, on the date stated above, at *9:15 P. m.*

The CAUSE OF DEATH* was as follows:

Rickets

CONTRIBUTORY (Secondary)

(duration)

enlargement yrs. mos. ds.

(duration)

Brachopneumonia yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Brachopneumonia at J.H.H.

Did an operation precede death?

No Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Culture

(Signed)

W. H. H.

M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

HOPKINS HOSPITAL

DATE OF BURIAL

4/26 1920

20 UNDERTAKER

Commissioner Health,

Rev. Wm. C. Woodall

D42630

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42630

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

1711 E: Preston St.

CITY OF BALTIMORE: (No.

ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John F: Deal.

(a) RESIDENCE. NO.

1711 E: Preston St.

ST.

WARD.

(Usual place of abode)

69

10

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary A: Deal

6 DATE OF BIRTH (month, day, and year)

July 3rd 1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

69

10

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired 10 Yrs

(b) General nature of industry, business, or establishment in which employed (or employer)

Metal worker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

Md

10 NAME OF FATHER

Geo W: Deal

Balto

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary Boden

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

Md

14

Informant (Address)

Mary A: Deal

1711 E: Preston St

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 25 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 1 1920, to April 25 1920.

that I last saw him alive on April 25 1920.

and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Hemaphysoma
& Infarction of lung

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Degeneration of Blood Vessels

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

if not at place of death?

Residual

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed)

R. P. Carman

M. D.

427 1920 (Address)

1707 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St

20 UNDERTAKER

John J. J. J.

DATE OF BURIAL

Apr 28 1920

ADDRESS

2008 Wilkes

TION is very important. See instructions on back of certificate.

APR 27 1920

D42631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 S. Belvid Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 504 S. Belvid Ave ST., WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 13, 1908

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

11

5

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Hans Roland Frost

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Denmark

12 MAIDEN NAME OF MOTHER

Mary Hagel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Maryland

14

Informant (Address)

Hans Roland Frost 504 S. Roland Ave

15

Robert P. Harrison, Registrar

APR 27 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1920

17

I HEREBY CERTIFY, That I attended deceased from April 18, 1920, to April 26, 1920,

that I last saw him alive on April 26, 1920,

and that death occurred, on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Influenza

CONTRIBUTORY (Secondary) Acute Meningitis (duration) yrs. mos. 11 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Peckard, M. D.

Address) 3100 Abell Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Pauls Cemetery April 28, 1920

ADDRESS

20 UNDERTAKER

H. Sanderous

D42632

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42632

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 631 S Becker Ave ST. 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Bradyhouse(Residence in Baltimore: No. 631 S Becker Ave St.; 60 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Widowed

6-DATE OF BIRTH,

Dec 25th, 1857
(Month) (Day) (Year)

7-AGE,

68 yrs., 4 mos., ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework at home9-BIRTHPLACE,
(State or Country),New Jersey

10-NAME OF FATHER,

Edie Kahley11-BIRTHPLACE OF FATHER
(State or Country),New Jersey

12-MAIDEN NAME OF MOTHER

Abigail Leoney13-BIRTHPLACE OF MOTHER
(State or Country),New Jersey

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie M. Hutchison(Address) 631 S Becker Ave

15-

Robert P. Harrison,

APR 27 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 25th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 25 1920, to April 25 1920,
that I saw her alive on April 25th 1920,
and that death occurred, on the date stated above, at 10:55 p.m.

The CAUSE OF DEATH* was as follows:

Thromboplegia
(transient apoplexy)
(Duration) 3 yrs., mos., ds.CONTRIBUTORY
(Secondary)(Duration) yrs., mos., ds.

(Signed),

W. H. Schaefer (M. D.)
April 26, 1920 (Address) 634 S. E. 11th Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Carmel Cem.

DATE OF BURIAL,

April 29, 1920

20-UNDERTAKER

H. Sander Sons

ADDRESS

1700 E. 11th St.

D42633

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42633

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1000)

ST. 15

WARD

REGISTERED NO. C

FULL NAME

James Green

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1825 Lorman St.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

col.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

S.

6-DATE OF BIRTH,

1855
(Month) (Day) (Year)

7-AGE,

65

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Pikeville Md

10-NAME OF FATHER,

James Green

11-BIRTHPLACE OF FATHER (State or Country),

Pikeville Md

12-MAIDEN NAME OF MOTHER

Barnett Green

13-BIRTHPLACE OF MOTHER (State or Country),

Pikeville Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

James E. Green

(Address)

5-33 Redbank St

15-

Robert P. Harrison,

101

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

April 25, 1928
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy, inquiry.

thereon and from the evidence obtained by inquest, autopsy, inquiry.

and that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Traumatic lacerations by
motor car
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signature) John J. Gules M. D.

4-24, 1928 (Address) 2800

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mount Auburn

DATE OF BURIAL,

April 28, 1928

20-UNDERTAKER

John H. Owens

ADDRESS

538 28th

CAUSE OF DEATH in plain terms as far as possible. See instructions on back of certificate.

APR 27 1928

D42634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

widow

6-DATE OF BIRTH,

(Month) (Day) (Year)

7-AGE,

62

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Home work

9-BIRTHPLACE,

(State or Country),

D.C.

10-NAME OF FATHER,

Dont know

11-BIRTHPLACE OF FATHER

(State or Country),

Dont know

12-MAIDEN NAME OF MOTHER

Dont know

13-BIRTHPLACE OF MOTHER

(State or Country),

Dont know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Rlater

(Address)

1116 E. 1st St.

15-

Filed

Robert E. Harrison

Registrar.

Burial Permit clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 24

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 22 1920, to April 24 1920,

that I saw him alive on April 24 1920,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Influenza

(Signed)

H. S. Meard

4/26/20, 1020 (Address) 2005 Druid Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mount Auburn

DATE OF BURIAL,

April 28, 1920

20-UNDERTAKER

John H. Owens

ADDRESS

538 N. 1st St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42635

CERTIFICATE OF DEATH.

D42635

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 Ridgewood Road ST.; 29th WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. not a resident St.: _____ yrs. _____ mos. _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

F

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH

July

21

1897

7-AGE

72

9

mos.

6

ds.

If LESS than 1 day,

....hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Home

sco

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country)

Edinburgh Scotland

10-NAME OF FATHER

Charles Kerr

11-BIRTHPLACE OF FATHER (State or Country)

Scotland

12-MAIDEN NAME OF MOTHER

Jane Thom

13-BIRTHPLACE OF MOTHER (State or Country)

Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Esth. Lillian Brock

(Address)

114 Ridgewood Road

15-

Robert P. Harrison,

101

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

April

27

1920

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

April 26 1920, to April 27 1920,

that I saw her alive on April 27 1920,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Arterio-sclerosis
Heart Failure at 9 A. M. Had
Cerebral Hemorrhage Oct-1918-

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Coronary Arterio-sclerosis

(Duration) 15 yrs. 6 mos. + ds.

(Signed) M. Gibson Porter M. D.

Apr. 27, 1920.-(Address) 422 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State yrs. mos. 7 ds.

Where was disease contracted, if not at place of death? New Brunswick

Former or usual residence Rousesay New Brunswick

19-PLACE OF BURIAL OR REMOVAL

St. John's New Brunswick

DATE OF BURIAL

April 27, 1920

20-UNDERTAKER

H. W. Jackson & Sons Co

ADDRESS

McLellan & Orchard

important. See instructions on back of Certificate.

D42636

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2248 Brookfield Ave ST. 3 WARD)2-FULL NAME Charles Kaufman

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2248 Brookfield Ave St. 65 yrs. 6 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Widowed

6-DATE OF BIRTH

5 Sept1837

(Month)

(Day)

(Year)

7-AGE

83

yrs.

7

mos.

22

ds.

or

min.?

If LESS than

1 day, hrs.,

min.?

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

retired 045
clothing Merchant

9-BIRTHPLACE

(State or country)

Germany

10-NAME OF FATHER

Herz Kaufman

11-BIRTHPLACE OF FATHER

Germany

(State or country)

12-MAIDEN NAME OF MOTHER

Caroline Eisenman

13-BIRTHPLACE OF MOTHER

Germany

(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob Kaufman(Address) 2248 Brookfield Ave

15- Robert P. Harrison,

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

April 27 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 25 1920, to, April 26 1920,that I saw him alive on April 26 1920,and that death occurred, on the date stated above, at 9:00 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) yrs. mos. 4 1/2 ds.

Contributory (SECONDARY)

(Signed) R. J. Sauter M. D.[Address] 1813 E. Baltimore

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Chel. StationDATE OF BURIAL April 29 1920

20-UNDERTAKER

2 Ahrens & CoADDRESS 1611 Mad Ave

state CAUSE OF DEATH is very important. See instructions on back of certificate.

APR 27 1920

D42637

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42637

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST.; *3* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Ida Schwartz*(Residence in Baltimore: No. *1111 E Pratt St* St.; *12* yrs., *—* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *F*4-COLOR OR RACE *W*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *March 17 1920*

(Month)

(Day)

(Year)

7-AGE, *59*yrs. *—* mos. *—* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *SW 037*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Russia*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Russia*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Morris Schwartz*(Address) *1111 E Pratt St*

15-

APR 27 1920

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 27 1920*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from *March 17 1920* to *April 27 1920*, that I saw her alive on *April 27 1920*, and that death occurred, on the date stated above, at *5.05pm*. The CAUSE OF DEATH* was as follows:
Cardiac Dehydration Hypertension
Hypertension
(Duration) *6* yrs. *10* mos. *10* ds.
CONTRIBUTORY *Bronchopneumonia*
(Secondary) *Left base*
(Signed) *B. Sack* M. D.
April 27 1920 (Address) *Hebrew Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1111 E Pratt St*19-PLACE OF BURIAL OR REMOVAL, *Hebrew Hospital*DATE OF BURIAL, *April 28 1920*20-UNDERTAKER, *Wm. Harrison*ADDRESS *1127 E Balto. St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42638

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1742 E North Ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1742 E North Ave St.; 9 yrs., 9 mos., 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Feb 14, 1844
(Month) (Day) (Year)

7-AGE,

76 yrs., 2 mos., 11 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)Retired9-BIRTHPLACE,
(State or Country),Maryland

10-NAME OF FATHER,

James Craig11-BIRTHPLACE OF FATHER
(State or Country),Md

12-MAIDEN NAME OF MOTHER

Elizabeth Hooford13-BIRTHPLACE OF MOTHER
(State or Country),Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Allan Craig(Address) 3615 Forest Park Ave

15-

APR 27 1920

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 24 1920, to April 25 1920that I saw him alive on April 25 1920and that death occurred, on the date stated above, at 745 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration)....yrs....mos....ds.

CONTRIBUTORY
(Secondary)

(Duration)....yrs....mos....ds.

(Signed) W. H. Harrison M. D.April 26, 1920 (Address) 1540 N. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Woodlawn Cemetery

DATE OF BURIAL,

April 28, 1920

20-UNDERTAKER

W. H. Harrison

ADDRESS

3517 Springdale St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42639

D42639

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *119 Pearl* St.; *4* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *119 Pearl* St.; *14* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)

6-DATE OF BIRTH, *Dec 25, 1897*
(Month) (Day) (Year)

7-AGE, *22* yrs., *4* mos., *1* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Barber*
(b) General nature of industry, business, or establishment in which employed (or employer), *804*

9-BIRTHPLACE, (State or Country), *Italy*

10-NAME OF FATHER, *Rosario Cammarata*

11-BIRTHPLACE OF FATHER, (State or Country), *Italy*

12-MAIDEN NAME OF MOTHER, *Antonia Fitele*

13-BIRTHPLACE OF MOTHER, (State or Country), *Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Pasquale Cammarata*

(Address) *2436 W. Baltimore*

15-

Robert P. Harrison,

191..... Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Apr 26, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Feb 12, 1920*, to *Apr 26, 1920*, that I saw him alive on *Apr 23, 1920*, and that death occurred, on the date stated above, at *12:30* a.m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration).....yrs.....mos.....ds.
CONTRIBUTORY.....*Exhaustion*
(Secondary)

(Signed) *Luigi D. Di Stefano* M. D.
Apr 27, 1920 (Address) *407 W. Geyer St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *4-28, 1920*

20-UNDERTAKER, ADDRESS, *1318 E. Light*

APR 27 1920
261284DA

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42640

CERTIFICATE OF DEATH.

D42640

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3114 St. North an ST. 15 WARD)2-FULL NAME Samuel Cartellillo(a) RESIDENCE. No. 3114 St North ST. 15 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) Feb 25 19197 AGE Years 1 Months 2 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None9 BIRTHPLACE (city or town) Baltimore (State or country) MD10 NAME OF FATHER Alphonso Cartellillo11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)12 MAIDEN NAME OF MOTHER Mary Comarato13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)14 Informant Alphonso Cartellillo (Address) 3114 St North an15 Robert P. Harrison, Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26 19 2017 I HEREBY CERTIFY, That I attended deceased from Apr. 10, 19 20, to Apr. 26, 19 20.that I last saw him alive on Apr 26, 19 20.and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis -(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of NoWas there an autopsy? No

What test confirmed diagnosis?

(Signed) W.S. Webb M. D., 19 (Address) 3402 Clifton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy RedeemerApr 28 19 20

20 UNDERTAKER

ADDRESS

W.J. Dickner & Sons74 Pa

TION is very important. See instructions on back of certificate.

APR 27 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42641

CERTIFICATE OF DEATH.

54

D42641

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725 Byrd ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora Zephier(a) RESIDENCE. No. 1730 Byrd ST. 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Zephier6 DATE OF BIRTH (month, day, and year) Dec 26 / 1860

7 AGE

Years 54Months 3Days 29

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Homemaker(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Charles Zang11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Anna M. Baron13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant (Address) Adam Zephier
1732 Byrd St.

15

Filed

Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 19 20

17

I HEREBY CERTIFY, That I attended deceased from

Oct, 19 19, to April 25, 19 20that I last saw him alive on April 25, 19 20and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Pericarditis
Anemia
(duration) yrs. mos. ds.CONTRIBUTORY (Secondary) Splenic(duration) yrs. mos. ds. 4

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) H. R. Campbell, M. D.1922 (Address) 1644 Hancock

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill Cem.April 28 19 20

20 UNDERTAKER

ADDRESS

M. J. Flynn1422 Light

TION is very important. See instructions on back of certificate.

PR 28 1920

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE 42642

D42642

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Ignace Hospital 15* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mr. Henry X. Hall

(a) RESIDENCE. NO.

1703 Milton St. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *50* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widower

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Mary E. Hall*

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than
1 day, ____ hrs.
or ____ min.*70 yrs**?**?*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Pa*

10 NAME OF FATHER

Do not know

PARENTS

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Do not know

12 MAIDEN NAME OF MOTHER

Do not know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Do not know

14

Informant
(Address)*Mr. B. J. Hall
1703 Milton St.*

15

APR 28 1920

ROBERT B. TRAUTER
Registrar

Seal of Health Department

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 27 1920*

17

I HEREBY CERTIFY, That I attended deceased from

July 29, 1919, to April 27, 1920
that I last saw him alive on *April 27, 1920*and that death occurred, on the date stated above, at *1:40 P.m.*

The CAUSE OF DEATH* was as follows:

*Chronic interstitial nephritis
with hypertension and cardiac hypertrophy*(duration) *3* yrs. mos. ds.CONTRIBUTORY
(Secondary)*Nervous; Acute cardiac dilatation*

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date of ____Was there an autopsy? *No*What test confirmed diagnosis? *Clinical and histological*(Signed) *Danigan* M. D.19 (Address) *St. Ignace Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**Apr 29 1920*

20 UNDERTAKER

ADDRESS

Emmanuel T. Waller 723 W. 4th St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42641

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 S Patterson Park ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 504 S Patterson Park ave St.; 22 yrs., 2 mos., 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

Nov 5 1884, 1 (Month) (Day) (Year)

7-AGE,

35 yrs., 4 mos., 22 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House wife

9-BIRTHPLACE, (State or Country),

Poland

PARENTS.

10-NAME OF FATHER,

Mathew Misiora

11-BIRTHPLACE OF FATHER (State or Country),

Poland

12-MAIDEN NAME OF MOTHER

Agatha Segda

13-BIRTHPLACE OF MOTHER (State or Country),

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Biatek(Address) 504 S Patterson Park ave

APR 28 1920

DOBERT K KRAUTER

191. Bureau of Health Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

4, 27, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

4-11 1920, to 4-28 1920,that I saw her alive on 4-25 1920, (4-22-20)and that death occurred, on the date stated above, at 8-4 a.m.

The CAUSE OF DEATH* was as follows:

nephrolithiasis (Bilateral)(Duration) 1 yrs., 1 mos., 2 ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs., 1 mos., 3 ds.(Signed) R. R. Keyser M. D.4-27, 1920 (Address) 1243 - Light St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 yrs., 2 mos., 22 ds. In the State 22 yrs., 2 mos., 22 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Rosary Cemetery April 28, 1920

20-UNDERTAKER

ADDRESS

Charles H. Conklin 1243 E. Eager

D42645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19. S. Robinson ST.; 1 WARD)

2-FULL NAME

(Residence in Baltimore: No. 19. S. Robinson St.; 28 yrs., 0 mos., 0 da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

white

5-SINGLE,
MARRIED, ☒
DIVORCED,
OR SEVERED.
(Write the word.)

Married

6-DATE OF BIRTH,

Feb 25, 1876
(Month) (Day) (Year)

7-AGE,

44 yrs., 2 mos., 1 da.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Machinist
0319-BIRTHPLACE,
(State or Country)

Balto Co. Md.

10-NAME
FATHER

James E. Ayres

11-BIRTHPLACE
OF FATHER
(State or Country),

Md.

12-MAIDEN NAME
OF MOTHER

Anna D. Benson

13-BIRTHPLACE
OF MOTHER
(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Albert P. Ayres

(Address)

843 St. 34 St.

15-

APR 28 1920

ROBERT B. KRAUTER

Filed

191

BUTLER T. F. ...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 26, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 18 1920, to April 26 1920,that I saw him alive on April 25 1920,and that death occurred, on the date stated above, at 6 am

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) ... yrs. ... mos. 9 da.CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... da.

(Signed) John J. Miller M. D.428, 191... (Address) 255 E. 34 St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Louisa Park Cem4/29, 1920

20-UNDERTAKER

ADDRESS

Walter Davis3307 Paine St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42646

D42646

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 St. Carey ST.; 16 WARD)2-FULL NAME Mrs Minnie Campbell(Residence in Baltimore: No. 707 St. Carey St.; 16 yrs., 1 mos., 1 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Dec 12, 1859
(Month) (Day) (Year)

7-AGE, 60 yrs., 4 mos., 15 ds. If LESS than 1 day,hrs. or....min?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer). Housekeeper

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, Frederick Baughman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Campbell
(Address) 2328 N Penna Ave.

15-APR 28 1920
FILED ROBERT B. ERAUTHE
Burial Permitted

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 27, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 3 1919, to Apr 27 1920, that I saw her alive on Apr. 23 1920, and that death occurred, on the date stated above, at 7:30 a m.
The CAUSE OF DEATH* was as follows:

Carcinoma Uteri
(Duration) 2 yrs., 1 mos., 1 ds.
CONTRIBUTORY Sepsis and Debility
(Secondary) (Duration) 3 yrs., 3 mos., 1 ds.
(Signed) Geo. C. Shannon M. D.
Apr 27, 1920 (Address) 700 Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In theyrs.mos.ds. State

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western DATE OF BURIAL, April 28, 1920

20-UNDERTAKER William Cook ADDRESS 502 E. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 S. Robinson St.; 1 WARD)2-FULL NAME Harry Hugel(Residence in Baltimore: No. 719 S. Robinson St.; 6 yrs., 6 mos., 6 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male4-COLOR, OR RACE, white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married
(Write the word.)6-DATE OF BIRTH, June 24, 1883

(Month)

(Day)

(Year)

7-AGE, 36 yrs., 10 mos., 6 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Laborer Eng.(b) General nature of industry, business, or establishment in which employed (or employer), Baeto Dry Dock9-BIRTHPLACE, (State or Country), Baeto Md10-NAME OF FATHER, Henry Hugel11-BIRTHPLACE OF FATHER (State or Country), Baeto Md12-MAIDEN NAME OF MOTHER Elizabeth Franke13-BIRTHPLACE OF MOTHER (State or Country), Baeto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie Hugel(Address) 719 S. Robinson St.

15-

APR 28 1920

ROBERT E. KRAUTER

Filed..... 191..

BALTIMORE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 27, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from April 15, 1920, to April 27, 1920, that I saw him alive on April 27, 1920, and that death occurred, on the date stated above, at 3:45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis
(Duration).....yrs.....mos.....ds.CONTRIBUTORY (Secondary) Dilated heart

(Duration).....yrs.....mos.....ds.

(Signed) W. H. Meavoy M. D.April 27, 1920 (Address) 839 S. Ellwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oakland Cem.DATE OF BURIAL, April 29, 192020-UNDERTAKER Lilly & Co. Inc.ADDRESS 403 S. W. 1st St.

NOTICE

The succeeding document
was received in the same
condition and microfilmed
as shown.

Every effort was made to
assure legibility and com-
pleteness.

1042648

HEALTH DEPARTMENT—CITY OF BALTIMORE

1042648

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 72nd. Grace and Hoop St.)

2-FULL NAME

Julian F. Jones

(Residence in Baltimore: No. 1917 Hope St.)

WARD 9

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

30 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

July 9, 1869

7-AGE,

41 yrs., 2 mos., 17 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Rigger

9-BIRTHPLACE, (State or Country),

md.

10-NAME OF FATHER,

Leon H. Jones

11-BIRTHPLACE OF FATHER (State or Country),

md.

12-MAIDEN NAME OF MOTHER

Elmira Kelly

13-BIRTHPLACE OF MOTHER (State or Country),

md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Law. Jones

(Address)

1917 Hope St.

15-

APR 28 1920

ROBERT R. KRAUTER

BRIAL PAINT RECTOR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr 26, 1920

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH was as follows:

Falling from a scaffold. Accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture of skull

(Duration) yrs. mos. ds.

(Signed) F. C. Du. Smith M. D.

(Coroner.) 910 Sept 18th

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hials Island Md

4/29/20

20-UNDERTAKER

ADDRESS

J. J. Turner

1442 N Broadway

Important. See instructions on back of certificate.

Rose Theda Kramer

D42649

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42649

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 100)

2-FULL NAME

(Residence in Baltimore: No. 14421

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH

7-AGE

8-LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

APR 28 1920

ROBERT E. KRAUTER

Bureau of Health Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry P. Sherry M. D.

(Coroner.)

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

20-UNDERTAKER ADDRESS

CAUSE OF DEATH in plain terms. important. See instructions on back of certificate.

D42650

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42650

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. New City HospitalST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Burns(a) RESIDENCE. No. Unknown

(Usual place of abode)

ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE 81 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) Ireland
(State or country)10 NAME OF FATHER Peter Burns11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)12 MAIDEN NAME OF MOTHER Annie Conroy Apr 27 192013 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14

Informant Hospital Records
(Address) New City Hospital.

15

Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1920

17

I HEREBY CERTIFY, That I attended deceased from April 9, 1920, to April 27, 1920 that I last saw him alive on April 26, 1920 and that death occurred, on the date stated above, at 1:00 A. m.

The CAUSE OF DEATH* was as follows:

Pyomphrosisunknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

unknown (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. P. Pessel, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

W. Wiedefeld Jr.April 29 1920Sumner

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42651

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 E. Monument St. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Eugene Hilliard

(a) RESIDENCE. No. 1609 E. Monument St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 19 mos.

ds. How long in U. S. if of foreign birth?

yrs. 19 mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Oct 26 1918

6 DATE OF BIRTH (month, day, and year)

7 AGE,

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Eugene Hilliard

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

William Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Eugene Hilliard 1609 E. Monument St.

15

APR 28 1920

ROBERT B. KRAUTER

Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 27 1920

17

I HEREBY CERTIFY, That I attended deceased from April 24, 1920, to April 27, 1920, that I last saw him alive on April 27, 1920, and that death occurred, on the date stated above, at 7:30 A. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

convulsions

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. J. W. Kennard, M. D.

April 27 1920 (Address) 708 E. 3rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lancaster Cemetery

4/28 1920

20 UNDERTAKER

Lancaster Cemetery

ADDRESS

5th St. Baltimore

D42652

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42652

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital*ST.: *11*

WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Mary Jones*(a) RESIDENCE. No. *9 E. Preston St.*

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life*

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married (Widowed or Divorced (write the word)

*Female Colored**Widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Widow*6 DATE OF BIRTH (month, day, and year) *1850*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

70 yrs

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *General Nurse*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto Md*10 NAME OF FATHER *Thomas Jones*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*

PARENTS

14 Informant (Address) *Mrs. Rose Jones*

15

APR 28 1920

ROBERT B. KRAUTER Registrar

Baptist Par. Mt. St. Mary

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr, 25 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*April 15, 1920, to April 25, 1920,*that I last saw her alive on *April 25, 1920,*and that death occurred, on the date stated above, at *6 P. M.*

The CAUSE OF DEATH* was as follows:

*Cerebral Apoplexy*CONTRIBUTORY (Secondary) *Myocardial Insufficiency*18 Where was disease contracted if not at place of death? *9 E. Preston St.*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

Signed) *W. G. Hayes*

APR 25 1920

(Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Laurel Ave**Apr, 28 1920*

20 UNDERTAKER

ADDRESS

Laurel Ave 578 M. B.

N. B.—WHITE FORM—Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42653

CERTIFICATE OF DEATH.

D42653
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 175-002)

2-FULL NAME

(Residence in Baltimore No. 513 S. Ellwood

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,

...hrs. or...mths.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer)

9-BIRTHPLACE,

(State or Country),

10-NAME OF

FATHER,

11-BIRTHPLACE

OF FATHER

(State or Country),

12-MAIDEN NAME

OF MOTHER

13-BIRTHPLACE

OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

101

ROBERT F. KAUTER

Baptist Church

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereof and from the evidence obtained by said

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY

(Secondary)

(Signed)

4-27

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42651

CERTIFICATE OF DEATH.

81 D42651

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2326 E. Fayette* ST.; *6* WARD)2-FULL NAME *Laura V. Foster*(a) RESIDENCE. NO. *2326 E Fayette* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

*White*5 Single, Married, Widowed,
or Divorced (write the word)*Married*5a If married, widowed, or divorced
husband
(or) WIFE of *John Foster*6 DATE OF BIRTH (month, day, and year) *Dec 31 / 1842*

7 AGE

77

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*None*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore Md*10 NAME OF FATHER *Samuel Brady*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*N. S. A*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)*John J. Foster*
2326 E. Fayette

15

Filed

*APR 28 1920**ROBERT A. KRAUTER**Marial Form 1-10-19*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 26 1920*

17

I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1919 to *April 26, 1920*that I last saw him alive on *April 26, 1920*and that death occurred, on the date stated above, at *12:00 A* m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis(duration) *2* yrs. *2* mos. *2* ds.CONTRIBUTORY
(Secondary)*Pulmonary Arterio*
(duration) *2* yrs. *2* mos. *2* ds.18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Edward J. Cook M. D.
4/26, 1920 (Address) *413 N. Washington**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Barnabas Cem.**Apr. 28 1920*

20 UNDERTAKER

*Philip Herwig*ADDRESS *2016**Orleans*

TION is very important. See instructions on back of certificate.

D42655

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42655

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Bay View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 8 WARD)

2-FULL NAME

Helen Sloan

(a) RESIDENCE. NO.

1225 N. Bond

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 50 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

Aug 18 78 29

7 AGE

70

Years

Months

8

Days

8

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

None

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Ireland.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Do.

12 MAIDEN NAME OF MOTHER

Do.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)Bay View Hospital
Baltimore, Md.

15

Filed APR 28 1920

ROBERT B. LEAVER

Registrar

Baltimore, Md.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 26 1920

17

I HEREBY CERTIFY, that I attended deceased from

April 14, 1920, to April 26, 1920

that I last saw him alive on April 26, 1920.

and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Senile Dementia &
Scurvy

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. J. Smith M. D.

4/27/20 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cem.

Apr. 30 1920

20 UNDERTAKER

ADDRESS 2816

Philip Sternig

Orleans St.

TION is very important. See instructions on back of certificate.

D42656

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42656

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

University Hospital

ST.

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Wade H. Burgess

(Residence in Baltimore: No. 27. E. Fort an.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Aug 23, 1880
(Month) (Day) (Year)

7-AGE,

39 yrs. 8 mos. 4 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Water Tender

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Rose Burgess

(Address)

27. E. Fort an

15-

ROBERT H. KRAUTER

Filed

APR 28 1920

191

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

april 27, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said

and that said deceased came to death

(Inquest, autopsy, or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Burgess on Body Caused by
bursting water pipe at 426 S. Kenton St.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Accidental bursting of pipe

(Duration) yrs. mos. ds.

(Signed) W. H. Garrison M. D.
(Coroner.)

4. 28, 1920 (Address) 17. W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Market Md.

4/29, 1920

20-UNDERTAKER

ADDRESS

J. Faw M. Cully 130 E. Fort

CAUSE OF DEATH in plain terms, to be stated in plain language, is important. See instructions on back of certificate.

D42657

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 824 Brooks Lane ST.: 13 WARD)

2-FULL NAME

(a) RESIDENCE. NO.

824 Brooks Lane ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 12/1847

7 AGE Years 72 Months 7 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Aaron Rider

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

APR 28 1920

ROBERT B. KRAUTER

Registrar

BRIAL F. MITCHELL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1920

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 1920, to April 27, 1920,

that I last saw him alive on April 27, 1920,

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Frederick Smith, M. D.

427, 1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore

April 29 1920

20 UNDERTAKER

ADDRESS

K. W. Bondheim

104 W. 11th St.

Information should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johna Hopkins Hosp. ST. 10* WARD)2-FULL NAME *Sam'l Thompson*3-RESIDENCE. No. *703 Sterling St.* ST.

(Usual place of abode)

WARD. *12th*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2 yrs.* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

4 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5 If married, widowed, or divorced HUSBAND of (or) WIFE of *Fannie Thompson*6 DATE OF BIRTH (month, day, and year) *Oct 15 - 1885*7 AGE Years *4* Months *11* Days *11* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

a) Trade, profession, or particular kind of work *Laborer* *040*

b) General nature of industry, business, or establishment in which employed (or Employer)

c) Name of employer

9 BIRTHPLACE (city or town) *Maryland* (State or country)10 NAME OF FATHER *Jim Thompson*11 BIRTHPLACE OF FATHER (city or town) *Maryland* (State or country)12 MARRIED NAME OF MOTHER *Fannie Johnson*13 BIRTHPLACE OF MOTHER (city or town) *Maryland* (State or country)14 Informant *Hospital Record* (Address) *H. H.*15 Filed *APR 28 1920* *ROBERT E. ERAUTER* Registrar *Serial Permit 61876*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 26 1920*17 I HEREBY CERTIFY, That I attended deceased from *April 16*, 1920, to *April 26*, 1920, that I last saw him live on *April 26*, 1920, and that death occurred, on the date stated above, at *1:30 P.* m.

The CAUSE OF DEATH* was as follows:

Chronic myelitis & leucemia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *Yes*What test confirmed diagnosis? *Yes*(Signed) *Wm. E. Purcell* M. D., 19 (Address) *J. H. Briggs*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Shurrs Cemetery**May 2 1920*

20 UNDERTAKER

ADDRESS

Charles B. Jones 2157 Pine

CAUSE OF DEATH is very important. See instructions on back of certificates.

This information is hereby printed to keep the present certificate correct by printing the present information on the back of the certificate.

D42659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42659

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Henson(a) RESIDENCE. NO. Unknown
(Usual place of abode)

ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black5 Single, Married, Widowed,
or Divorced (write the word)Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1882

7 AGE

Years

Months

Days

38If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work Warehouse Man(b) General nature of industry,
business, or establishment in
which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)10 NAME OF FATHER Thomas Crocker11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)12 MAIDEN NAME OF MOTHER Nannie Wicks Apr. 27, 192013 BIRTHPLACE OF MOTHER (city or town) Saint Mary's
(State or country) Md.

14

Informant Hospital Records
(Address) New City Hospital.

15

APR 28 1920ROBERT A. FRANKLINBurial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1920

17

I HEREBY CERTIFY, That I attended deceased from
April 8, 1920, to April 27, 1920.
that I last saw him alive on April 27, 1920.
and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial InsufficiencyCONTRIBUTORY (Secondary) Multiple Infarcts of lung
(duration) yrs. 2 mos. ds.18 Where was disease contracted
If not at place of death? UnknownDid an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? No special tests(Signed) J. Pessel, M. D.Address) New City Hospital.*State the Disease Causing Death, or in deaths from Violent Causes,
state (4) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. AuburnApr 30 1920

20 UNDERTAKER

John H. TordinADDRESS 192West 44

TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42660

D42660

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2011 Spruce

ST.: 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Stanek

(a) RESIDENCE. No. 2011 Spruce

ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? 16 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female white widow

5a If married, widowed, or divorced
HUSBAND of John Stanek
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850- - - -

7 AGE Years Months Days If LESS than 1 day, 3 hrs. or min.
70 years ? ?

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packing house hand

(b) General nature of industry, business, or establishment in which employed (or employer) fruit canning

(c) Name of employer Fote's Packing Co.

9 BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Sabistijan Karpinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs. Josephine Borovick.
(Address) 1910 Fleet St.15 Filed APR 28 1920 ROBERT E. LEAUTEAU
Serial Permit No. 10707

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 27 1920

17 I HEREBY CERTIFY, That I attended deceased from
Mar. 17, 1920, to Apr. 27, 1920,
that I last saw her alive on Apr. 24, 1920,
and that death occurred, on the date stated above, at 4:30 p. m.The CAUSE OF DEATH* was as follows:
carcinoma of transverse
colon.

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY exhaustion, —
(Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted
if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward A. Novak M. D.

, 19 (Address) 821 N. Paul. Pr. av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Stanislaus Church April 30 1920

20 UNDERTAKER ADDRESS

M. F. Sadowski 405 S. Ann St.

TION is very important. See instructions on back of certificate.

D42661

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1400 Johnson*)ST. *24* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Peter Poyal(Residence in Baltimore: No. *1400 Johnson*)St.; *40* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *M* 4-COLOR OR RACE, *W* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *widow*

6-DATE OF BIRTH, *March 27*, 18*55*.
(Month) (Day) (Year)

7-AGE, *65* yrs., *1* mos., ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Labr*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country).

Ireland

10-NAME OF FATHER.

John Poyal

11-BIRTHPLACE OF FATHER
(State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

Elizabeth Devith

13-BIRTHPLACE OF MOTHER
(State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

1400 Johnson

15-

APR 8 1920

Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

4 *27*, 19*20*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *4.18* 19*20*, to *4.27* 19*20*, that I saw him alive on *4.27* 19*20*, and that death occurred, on the date stated above, at *3.15* p.m.

The CAUSE OF DEATH* was as follows:

Chronic duodenal hepatitis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocarditis
(Duration) yrs. mos. ds.

(Signed) *J. H. Mullington* M. D.
4.27, 19*20*. (Address) *102 E. Fort Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Cathedral Cem.

DATE OF BURIAL.

April 30, 1920

20-UNDERTAKER

M. S. Flynn

ADDRESS

1422 Light

D42662

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42662

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST.: *7* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Joshua F. Covey

(a) RESIDENCE. NO.

(Usual place of abode) *Duxton, Md* ST.: *12th* WARD. *12th*
Length of residence in city or town where death occurred *Life* yrs. *1* mos. *14* ds.
How long in U. S., if of foreign birth? yrs. *1* mos. *14* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Sarah Covey

6 DATE OF BIRTH (month, day, and year)

Sept 28-1848

7 AGE

71 Years *7* Months *5* Days
If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Thomas Covey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Satterfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Hospital Record
Robert P. Harrison,

Registrar

APR 28 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 26* 19*20*17 I HEREBY CERTIFY, That I attended deceased from *March 19*, 19*20*, to *April 26*, 19*20*.that I last saw him alive on *April 26*, 19*20*.and that death occurred, on the date stated above, at *12 00* m.

The CAUSE OF DEATH* was as follows:

Emphysema

(duration)

yrs.

mos. *3*

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *1*

Date of

Was there an autopsy? *yes*What test confirmed diagnosis? *yes*

(Signed)

Dr. Brown Field, M. D.

19

(Address)

Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Federalburg, Louisiana, La**Apr. 30 1920*

20 UNDERTAKER

H. E. Hughes 17 S. Broadway

D42663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *116 Welcome ally* ST.; *22* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *116 Welcome ally* St.; *20* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

Widow
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Unc known (Month) (Day) (Year) *1869*

7-AGE,

51 yrs. mos. ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Housework*9-BIRTHPLACE,
(State or Country),*New Orleans Louisiana*

10-NAME OF FATHER,

*unknown*11-BIRTHPLACE OF FATHER
(State or Country),*unknown*

12-MAIDEN NAME OF MOTHER

*unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Harry Cornish

(Address)

116 Welcome ally

15-

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 27, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *apr 25* 1920, to *April 26* 1920, that I saw her alive on *April 26* 1920, and that death occurred, on the date stated above, at *4:30 a.* m.

The CAUSE OF DEATH* was as follows:

Primary General debility
Immediate - Exhaustion
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

april 27 1920 (Address) *506 H. Avenue*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Auburn *April 29 1920*

20-UNDERTAKER

ADDRESS

L. H. Brown & Son *108 W. Montg*

APR 28 1920

D42661

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42661

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Balt. Gen. Hospital* ST. *24* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Baby Worely

(Residence in Baltimore: No. _____ St. _____ yrs. _____ mos. _____ ds.)

St. _____ yrs. _____ mos. _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

4 - 21, 1920
(Month) (Day) (Year)

7-AGE,

X yrs. *2* mos. *2* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Cal.

PARENTS.

10-NAME OF FATHER,

Not Known -

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

Pearline Worely

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland (Howard Co.)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

*Robert P. Harrison,**Burial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

4 23 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*4 - 21 19120, to 4 - 23 19120*that I saw him alive on *4 - 23 19120*and that death occurred, on the date stated above, at *1-6 m.*

The CAUSE OF DEATH* was as follows:

1- Congenital Atresia
2- Anatomical anomaly - (Nidus)
R. Auricle

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....*R. P. Reynolds*.....M. D.*4-23, 1920* (Address) *123 Light St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

HOPKINS HOSPITAL

DATE OF BURIAL,

....., 191...

20-UNDERTAKER
*Commissioner Health.*ADDRESS *1920*

Per. Wm. E. Woodall.

D42665

HEALTH DEPARTMENT—CITY OF BALTIMORE

42665

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Small(a) RESIDENCE. NO. 18-20th St.

(Usual place of abode)

ST., _____ WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)MaleBlackSingle5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1884

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.36

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workLaborer(b) General nature of industry,
business, or establishment in
which employed (or employer)Unknown

(c) Name of employer

Unknown9 BIRTHPLACE (city or town) Jacksonville,
(State or country) Florida10 NAME OF FATHER Samuel Small11 BIRTHPLACE OF FATHER (city or town) Tennessee
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) South Carolina
(State or country)

14

Informant Hospital Records

(Address)

New City Hospital

15

Filed Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1920

17

I HEREBY CERTIFY, That I attended deceased from

February 28, 1920, to April 25, 1920that I last saw him alive on April 25, 1920and that death occurred, on the date stated above, at 11:40 A.M.

The CAUSE OF DEATH* was as follows:

Ulcerative Pulmonary Tuberculosis;
Tuberculous Broncho-Pneumonia(duration) _____ yrs. 4 mos. _____ ds.CONTRIBUTORY Multiple Tubercular Joints
(Secondary)(duration) _____ yrs. 4 mos. _____ ds.18 Where was disease contracted
if not at place of death?CityDid an operation precede death? No Date of _____Was there an autopsy? NoWhat test confirmed diagnosis? Sputum Examination(Signed) J. P. Harrison

M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL New City HospitalState the Disease Causing Death, or in deaths from Violent Causes,
(1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner Health

Rep. Wm. E. WOODALL

TION is very important. See instructions on reverse side.

APR 28 1920

Burial Permit Clerk

APR 28 1920

D42666

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42666

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST. 10 WARD)

REGISTERED No. C

2-FULL NAME William A. Wilson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. _____ St. 4 yrs. _____ mos. _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE,

married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

_____, 1 _____
(Month) (Day) (Year)

7-AGE,

50 yrs. _____ mos. _____ ds.

If LESS than 1 day,

____ hrs. or ____ min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Steam Fitter9-BIRTHPLACE,
(State or Country),West Virginia

10-NAME OF FATHER,

unknown11-BIRTHPLACE OF FATHER
(State or Country),unknown

12-MAIDEN NAME OF MOTHER

unknown13-BIRTHPLACE OF MOTHER
(State or Country),unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....John F. Leonard(Address).....Md. Penitentiary

15-

Filed APR 28 1920

Robert P. Harrison,

Bureau Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April-13, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from February-21 1916, to April-13 1920, that I saw him alive on April-13 1920, and that death occurred, on the date stated above, at 9:10 a.m. The CAUSE OF DEATH* was as follows:Acute Cardiac Dilatation
Angina Pectoris

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY

Arteriosclerosis (Alcoholism)
(Secondary) (Duration) 4 yrs. 1 mos. 22 ds.(Signed) William F. Schwartz M. D.April-13, 1920 (Address) Md. Penitentiary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 yrs. 2 mos. 5 ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

Commissioner Health.

APR 29 1920

Per. Wm E. WOODALL

D42667

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42667

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1547 Street ST. 3 WARD)2-FULL NAME Charles Morgan(Residence in Baltimore: No. 1547 Street St)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male4-COLOR OR RACE, White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single6-DATE OF BIRTH, March 1

(Month)

(Day)

(Year)

7-AGE, 60

YRS.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Salvage

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), Maryland10-NAME OF FATHER, Morgan11-BIRTHPLACE OF FATHER (State or Country), "12-MAIDEN NAME OF MOTHER "13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert P. Harrison(Address) Bank St

15-

Robert P. Harrison,

Filed.

191

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 14, 1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest (Inquest, au-topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

apoplexy
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry J. Smith M. D.(Address) 1610 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

Commissioner Health.

ADDRESS

APR 20 1920

Per. Wm. E. WOODAL

important. See instructions on back of certificate.

D42668

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42668

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 Forrest Street

ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Bernard A. Murdock

50 Years

(a) RESIDENCE. NO.

1114 Forrest Street

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

Belle W. Murdock

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1858

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

62

1

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer)

Steam Railroad

(c) Name of employer

Penna. R. R.

9 BIRTHPLACE (city or town) (State or country)

Charles County Maryland

10 NAME OF FATHER

Richard E. Murdock

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Charles Co. Maryland

12 MAIDEN NAME OF MOTHER

Mary Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Charles Co. Maryland

14

Informant (Address)

Mrs. Belle W. Murdock

1114 Forrest St.

Robert F. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26, 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1919, to Apr. 26, 1920,

that I last saw him alive on April 26, 1920.

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease
Aortic Insufficiency

(duration) - yrs. 4 mon. - ds.

* * * * *

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted * * * * * if not at place of death?

Did an operation precede death? no Date of * * *

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Edw. M. Seymour, M. D.

Apr. 27, 1920 Address) 5 N. Washington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

W. H. Cook

20 UNDERTAKER London Park Cem.

ADDRESS April 27/20

PR 28 1920

19

D42669

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42669

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *22 Augusta Ave* ST. *20* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Francis Louis Ward

(a) RESIDENCE. NO.

22 Augusta Ave ST. *20* WARD. *(Resident)*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

11 yrs. *?* mos. *?* ds.

How long in U. S., if of foreign birth?

71 yrs. *11* mos. *16* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

(Single)

6 DATE OF BIRTH (month, day, and year)

May-10-1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*71**11**16*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Soldier

(c) Name of employer

U.S. Government

9 BIRTHPLACE (city or town) (State or country)

Annapolis Junction Howard Co. Maryland

10 NAME OF FATHER

John Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Margaret MacMillan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Leo D. Ward - (Nephew) 22 Augusta Ave

15

Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-26-1920

17

I HEREBY CERTIFY, That I attended deceased from

*March 20, 1920, to April 26, 1920,*that I last saw him alive on *April 26, 1920,*and that death occurred, on the date stated above, at *5 P* m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

CONTRIBUTORY (Secondary)

(duration) *Not Known* yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *No*Was there an autopsy? *No*

What text confirmed diagnosis?

(Signed) *Howard W. Jones* M. D.(Address) *222 Augusta Ave*

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Catholic Cemetery**Apr 29, 1920*

20 UNDERTAKER

STEWART & MOWEN COMPANY

(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

TION is very important. See instructions on back of certificate.

APR 28 1920

Burial Permit Clerk.

D42670

Pearl Kane
HEALTH DEPARTMENT—CITY OF BALTIMORE

D42670

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. *Hopkin Hospital* ST. *5*)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. *801 Law St.*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *7* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*W.C.*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *P.*

6-DATE OF BIRTH,

Feb. 14, 1912
(Month) (Day) (Year)

7-AGE,

8 yrs. 2 mos. 16 ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*school*

9-BIRTHPLACE, (State or Country),

Va.

10-NAME OF FATHER,

William Kane,

11-BIRTHPLACE OF FATHER (State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Louisa Reed

13-BIRTHPLACE OF MOTHER (State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

William Kane

(Address)

801 Law St.

15-

Robert P. Harrison,

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr 26, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held in (Inquest, autopsy or inquiry.)

and from the evidence obtained by said (Inquest, au-

topsy and that said deceased came to death the day stated above.

The CAUSE OF DEATH was as follows:

Acute Pancreatic crisis by mistake.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Wm. J. Miley* M. D.(Coroner) (Address) *191*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Farmville Va.*

19-PLACE OF BURIAL OR REMOVAL,

Farmville Va.

DATE OF BURIAL,

April 29, 20

20-UNDERTAKER

ADDRESS

Harry A. Voderly 1725 Orleans St.

important. See instructions on back of certificate.

APR 28 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42671

CERTIFICATE OF DEATH.

D42671

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *226 S. Register* ST.: *79* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *226 S. Register* St.: *40* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

August 20, 1886
(Month) (Day) (Year)

7-AGE.

64 yrs. 8 mos. 7 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Germany

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Martin W. Dwyer*(Address) *27 S. ...*

15-

*Robert P. Harrison,**Registrar.*
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Apr 27, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Apr 26, 1920, to Apr 26, 1920,*that I saw *her* alive on *Apr 26, 1920,*and that death occurred, on the date stated above, at *2 P.M.*

The CAUSE OF DEATH* was as follows:

Cardiac dilatation(Duration) *7 yrs. 7 mos. 7 ds.*

CONTRIBUTORY (Secondary)

Pulmonary Edema(Signed) *J. W. Wheaton* M. D.*Apr 27, 1920.* (Address) *28 S. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Holy Redeemer

DATE OF BURIAL.

Apr 27, 1920

20-UNDERTAKER

Wendell Dwyer

ADDRESS

37 S. ...

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42672

D42672

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1925 E Lombard ST.; 2 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Abel(Residence in Baltimore: No. 1925 E Lombard St.; 68 yrs., 10 mos., 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married
(Write the word.)6-DATE OF BIRTH, June 16, 1957
(Month) (Day) (Year)7-AGE, 68 yrs., 10 mos., 11 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), BaltimorePARENTS.
10-NAME OF FATHER, John Abel
11-BIRTHPLACE OF FATHER (State or Country), Germany
12-MAIDEN NAME OF MOTHER, Katharina Abel
13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Abel(Address) 1925 E Lombard

15-

Robert P. Harrison,Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 27, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Dec 18, 1918, to April 27, 1920, that I saw him alive on April 27, 1920, and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage..... (Duration) 2 yrs., 10 mos., 11 ds.CONTRIBUTORY (Secondary) Chronic nephritis..... (Duration) 7 yrs., 10 mos., 11 ds.(Signed) Leo Heller M. D.4-28, 1920 (Address) 1937 South St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy RedeemerDATE OF BURIAL, April 30, 192020-UNDERTAKER, Wendell Puffel & SonADDRESS, 378 N. Ave

Important: See instructions on back of card.

APR 28 1920

D42673

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42673

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *121 N Dallas St*) ST. *6* WARD)

2-FULL NAME

(Residence in Baltimore: No. *121 N Dallas St*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *63* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *Col* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)

6-DATE OF BIRTH,

(Month) (Day) (Year) *1*

7-AGE,

63

yrs. mos. ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Labourer*9-BIRTHPLACE,
(State or Country),*Balti*

10-NAME OF FATHER,

*Not Known*11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

*not known*13-BIRTHPLACE OF MOTHER
(State or Country),*not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Annie L. Lee*(Address) *121 N. Dallas St*

15-

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH,

April 26, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an

Inquest, autopsy or inquiry
thereon and from the evidence obtained by saidInquest, au-
topsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia due to hanging

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wm. H. Dwyer
(Coroner.)
1127 10th St
(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,

Laurel Cemetery

20-UNDERTAKER

Sam. W. Chase-son

DATE OF BURIAL,

Apr 29th 1920

ADDRESS

1400. Mosher St

See instructions on back of certificate.

APR 28 1920

D42671

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42671

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 W. 36 ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 1512 W. 36 ST. 13 WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds.

How long in U. S., if of foreign birth 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) Jan 24/1854

7 AGE Years 66 Months 4 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Columbus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Harriet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14

Informant (Address)

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 27, 1920, to April 27, 1920.

that I last saw him alive on April 27, 1920.

and that death occurred, on the date stated above, at 5:50 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
Right Hemiplegia

(duration) yrs. mos. 3 mos.

CONTRIBUTORY (Secondary)

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Address 3549 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

TION is very important. See instructions on back of certificate.

APR 28 1920

D42675

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42675

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *William Kountz*(a) RESIDENCE. NO. *Westminster Md* WARD. *Westminster Md*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

9

ds.

How long in U. S., if of foreign birth?

Life yrs.

mos.

7

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

80

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

George Kountz

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Sarah Erb.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

*Harvey Baulsard**Westminster Md**Robert P. Harrison,**19*

Registrar

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-28 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

April 19, 19 *20*, to *April 28*, 19 *20*.that I last saw him alive on *April 28*, 19 *20*.and that death occurred, on the date stated above, at *1* P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis and Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Md.

Did an operation precede death?

yes

Date of

4/26/20

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed) *Nathan Greenlow*, M. D.19 (Address) *Union St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Westminster

20 UNDERTAKER

*H Bankard Son**5/1*19 *20*

ADDRESS

Westminster

TION is very important. See instructions on back of certificate.

APR 28 1920

D42676

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D42676

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St. 64 yrs. 2 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word)

6 DATE OF BIRTH *Feb* *24*, 1856
(Month) (Day) (Year)

7 AGE *64* yrs. *2* mos. *3* ds. IF LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work *Board Solicitor*
(b) General nature of industry, business, or establishment in which employed (or employer) *Not Employed*

9 BIRTHPLACE
(State or country)*Balto. Md*

10 NAME OF FATHER

*James W Sweet*11 BIRTHPLACE OF FATHER
(State or country)*Rhode Island*

12 MAIDEN NAME OF MOTHER

*Emily Mathelet*13 BIRTHPLACE OF MOTHER
(State or country)*Balto. Md*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs James W. Sweet
239 W. Lanvale St.

15.

*Robert P. Harrison**Burial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *April* *27*, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec, 1919, to *April*, 1920that I saw him live on *April* *26*, 1920and that death occurred, on the date stated above, at *9 a* m.

The CAUSE OF DEATH* was as follows:

*Chronic interstitial
nephritis & myocardial
insufficiency*

(Duration) *2* yrs. mos. ds.Contributory
(SECONDARY)*uremia*(Duration) *6* yrs. mos. ds.(Signed) *J. M. Arnold* M. D.*April 27, 1920* (Address) *1009 Cathedral St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Frederick Ind.**April 29, 1920*

20 UNDERTAKER

ADDRESS

Harry H. Witzke *1531 W. Lombard.*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

APR 28 1920

D42677

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D42677

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 4032 Falls Road ST. 13 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edward C. M. Rye

(a) RESIDENCE. No. 4032 Falls Road ST. 13 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. - mos. - ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of Sarah C. Rye (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 30 - 1846

7 AGE Years 73 Months 7 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired 18 years

(c) Name of employer

9 BIRTHPLACE (city or town) Cumberland Maryland (State or country)

10 NAME OF FATHER

James Rye

11 BIRTHPLACE OF FATHER (city or town) Pennsylvania (State or country)

12 MAIDEN NAME OF MOTHER

Susan Johnston

13 BIRTHPLACE OF MOTHER (city or town) Cumberland Maryland (State or country)

14 Informant Ida May Gibbons (Address) 4032 Falls Road

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1920

17

I HEREBY CERTIFY, That I attended deceased from

Dec. 14, 1918, to April 27, 1920,

that I last saw him alive on April 26, 1920,

and that death occurred, on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY Initial Regurgitation (Myocarditis) (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) J. H. Maclean, M. D.

19 (Address) 4119 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Paul's Granite, Md.

April 29 1920

20 UNDERTAKER

ADDRESS

Horace Burge-son

3631 Falls Rd.

TION is very important. See instructions on back of certificate.

PR 28 1920

Burial Permit Clerk Registrar

D42678

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42678

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE

MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert F. Harrison,

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17-I HEREBY CERTIFY, That I attended deceased from

that I saw h. *er* alive onand that death occurred, on the date stated above, at 2:30 *PM*.

The CAUSE OF DEATH* was as follows:

Myocarditis(Duration) *3* yrs. *5* mos. *5* ds.CONTRIBUTORY (Secondary) *Intestinal obstruction*(Duration) *5* yrs. *5* mos. *5* ds.(Signed) *Edgar B. Sautrock* M. D.apr. 28, 1920 (Address) *1601 N. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *yr.* *mos.* *ds.* In the State *yr.* *mos.* *ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

APR 28 1920

Burial Permit Clerk

Registrar.

20-UNDERTAKER

Address

104

D42679

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2320 Fleet St.; 7 yrs., 7 mos., 29 da.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 28th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
April 25 1940, to April 20 1940,
that I saw him alive on April 25th 1940,
and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Marasmus

CONTRIBUTORY Gastro-Enteritis
(Secondary).....
Indefinite (Duration)..... yrs..... mos..... d

(Signed) John A. Miller M. I.

4/25/10, 10120 (Address) 2727 1st St. N.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSFERREES, OR RECENT RESIDENTS).

At place of death yrs. mo. da. In the State yrs. mo. da.

Where was disease contracted,
if not at place of death?.....

Former or
usual residence

10-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,

Holy Rosary, April 29, 1942

20-UNDERTAKER	ADDRESS
W. F. A. Dowd	405 S. Ann St.

Important: See instructions on back of

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42680

D42680

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Michael M. Dermott

(a) RESIDENCE. No.

Little Sisters of the Poor ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

50 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 50 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Irish

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.78

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Michael M. Dermott

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Sister of Benedict

15

APR 29 1928

ROBERT E. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr. 27 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 9, 1920, to Apr. 27, 1920,that I last saw him alive on Apr. 27, 1920,and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Senile gangrene
arterio sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocardial infarction

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical(Signed) W. M. Claver, M. D., 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

CathedralApr 29 1920

20 UNDERTAKER

ADDRESS

H. C. Wiedefeld 914 Greenbush

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42682

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 S. Sharp ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Virginia Long(Residence in Baltimore: No. 310 S. Sharp St.; 2 yrs., mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. F. 4-COLOR OR RACE, C. 5-SINGLE, MARRIED, Single WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Apr. 1, 1917
(Month) (Day) (Year)

7-AGE, 2 yrs., 26 mos., 26 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, Earnest Long

11-BIRTHPLACE OF FATHER, (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Maggie Brumton

13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earnest Long

(Address) 310 S. Sharp

15- APR 29 1920 ROBERT B. KRAUTER

Filed....., 191. ROBERT B. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 27, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr. 22 1920, to Apr. 27 1920, that I saw her alive on Apr. 24 1920, and that death occurred, on the date stated above, at 7:30 A. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary) (Duration).....yrs.....mos.....ds.

(Signed) Minny H. Long M. D.
Apr. 27, 192. (Address) 310 S. Sharp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. * In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Helena Apr. 29, 1920

20-UNDERTAKER, ADDRESS 114 W.

Brown & Greenland Schroeder

D42683

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

D42683

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *Sydenham Hospital* ST. WARD)FULL NAME *Roman Smialkowski*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *614 S. Milton Ave.* St. *2* yrs. *9* mos. *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

July 18, 1917
(Month) (Day) (Year)

7 AGE

2 yrs. 9 mos. 10 ds.

If LESS than 1 day, --- hrs. or --- min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*none*

9 BIRTHPLACE (State or country)

Ud.

PARENTS

10 NAME OF FATHER

Roman Smialkowski

11 BIRTHPLACE OF FATHER (State or country)

Ud.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

Ud.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Roman Smialkowski

(Address)

614 S. Milton St

APR 29 1920

ROBERT B. LAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 28, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*April 28, 1920 to April 28, 1920*that I saw him live on *April 28, 1920*and that death occurred, on the date stated above, at *6:00 a.m.*

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal(Duration) --- yrs. --- mos. *4* ds.

Contributory (SECONDARY)

(Duration) --- yrs. --- mos. --- ds.

(Signed)

William M. D.
April 28, 1920 (Address) *Sydenham Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death --- yrs. --- mos. --- ds. In the State --- yrs. --- mos. --- ds.

Where was disease contracted, if not at place of death?

at home

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Holy Rosary

DATE OF BURIAL

April 29, 1920

20 UNDERTAKER

M. Fialkowski 1618 Eastern Ave.

N.B.-Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

D42681

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42681

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

Franklin St. Hospital 16

WARD)

REGISTERED No. C

2-FULL NAME

Aaron Katz

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

2000 Edmonson Ave

St. (yrs., 12) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

Single

6-DATE OF BIRTH,

Unknown, 1

(Month)

(Day)

(Year)

7-AGE,

12

YRS. MOS. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

School Boy

9-BIRTHPLACE, (State or Country),

Balt City

10-NAME OF FATHER,

Wm Katz

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Lea Elberg

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm Katz

(Address)

2000 Edmonson Ave

15

Filed

APR 29 1920

101

ROBERT E. KRAUTER

Burial Form No. 1000

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 28, 1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an investigation (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of 7th rib
Auto accident

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Boy ran into auto

(Duration) yrs. mos. ds.

(Signed)

James M. Fulton

(Coroner.)

April 29 1920 (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Mulberry Street near Payson

Former or usual residence 2000 Edmonson Ave

19-PLACE OF BURIAL, OR REMOVAL,

Hebrew Burial

20-UNDERTAKER

Sol Friedman

DATE OF BURIAL,

April 29, 1920

ADDRESS

1419 Madison Ave

important. See instructions on back of certificate.

D42685

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42685

CERTIFICATE OF DEATH.

I-PLACE OF DEATH

CITY OF BALTIMORE: (No. *11* ST.: *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Bro. John D. Fortescue*(a) RESIDENCE. NO. *2040 Calver*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *48* yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *March 13, 1841*

7 AGE

Years *78*Months *11*Days *25*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Religious obs*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Manchester, England*
(State or country) *England*10 NAME OF FATHER *Patrick Fortescue*11 BIRTHPLACE OF FATHER (city or town) *Ireland*
(State or country)12 MAIDEN NAME OF MOTHER *May Cowley*13 BIRTHPLACE OF MOTHER (city or town) *Ireland*
(State or country)

14

Informant *Mercy Hospital Record*
(Address)

15

APR 29 1920

ROBERT J. KRAUTH
Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/27* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

4/25, 19*20*, to *4/27*, 19*20*.that I last saw him alive on *4/27*, 19*20*.and that death occurred, on the date stated above, at *3.45 a. m.*

The CAUSE OF DEATH* was as follows:

Blood-Pneumonia(duration) yrs. mos. *5* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no*

Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *John D. Keady*, M. D.*4/27* 19*20* (Address) *Mercy Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Woodstock, Md. State**4/29*, 19*20*

20 UNDERTAKER

Henry W. Mears *805 N. Calver*

CAUSE OF DEATH is very important. See instructions on back of certificates.

142686

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 S. Becker Ave. ST.: 1 WARD)2-FULL NAME George Stefan(a) RESIDENCE. No. 1226 S. Becker ST.: 1 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.How long in U. S., if of foreign birth? 40 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Stefan6 DATE OF BIRTH (month, day, and year) Not known7 AGE 62 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Frame maker(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cleveland, Ohio10 NAME OF FATHER John Stefan11 BIRTHPLACE OF FATHER (city or town) (State or country) Cleveland, Ohio12 MAIDEN NAME OF MOTHER Not known13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cleveland, Ohio

14

Informant (Address) Anna Stefan
1226 S. Becker Ave.

15

Filed APR 28 1920Burial Permit Blank Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 192017 4/22 HEREBY CERTIFY, That I attended deceased from 4/22 1920 to 4/28 1920, that I last saw him alive on 4-28 1920.and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

haemiplegia(Apoplexy)(duration) yrs. mos. ds. 5CONTRIBUTORY (Secondary) Exhaustion(duration) yrs. mos. ds. 318 Where was disease contracted if not at place of death? ✓Did an operation precede death? ✓ Date of 22 October 1919Was there an autopsy? ✓What test confirmed diagnosis? 22 October 1919(Signed) Harry Goldberger M. D.4-28-20 (Address) 2210 Bontaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy RosaryDATE OF BURIAL May 1 192020 UNDERTAKER Frank E. ...ADDRESS 1416 ...

TION is very important. See instructions on back of certificates.

Important: See instructions on back of certificate.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1313 W. Lombard ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 313 W. Lombard St. St.; 31 yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single (Write the word.)

6-DATE OF BIRTH. 1.0.1910, 1910 (Month) (Day) (Year)

7-AGE. 31 yrs. 5 mos. 22 ds. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country), Annapolis Md

10-NAME OF FATHER, Ambrose Hogan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Katherine Casack

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Nellie Casack

(Address) 1313 W. Lombard St.

15-

Filed APR 29 1920 191... REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 27, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1920, to April 27, 1920, that I saw her alive on April 27, 1920, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows: General Septicemia following Pharyngitis & Tonsillitis and with staphylococci (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D. April 27, 1920 (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Annapolis Md.

19-PLACE OF BURIAL OR REMOVAL, Annapolis Md DATE OF BURIAL, 4-30-1920

20-UNDERTAKER, H.B. Manning, Son Address 517 N. Calver Street

HEALTH DEPARTMENT—CITY OF BALTIMORE 12688

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1410 Carroll* ST.: *21* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Barbara Lucas*(a) RESIDENCE. NO. *1410 Carroll St.* ST.: *21* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *Caucasian*5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *1857*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country) *Baltimore Md*10 NAME OF FATHER *John Lucas*11 BIRTHPLACE OF FATHER (city or town). (State or country) *Baltimore Md*12 MAIDEN NAME OF MOTHER *Lucas*13 BIRTHPLACE OF MOTHER (city or town). (State or country) *Baltimore Md*

14

Informant (Address) *Max Greenbaum 1404 Mad St*

15

APR 29 1920

ROBERT E. KAUTER Registrar

Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 26 1920*

17

I HEREBY CERTIFY, That I attended deceased from *Nov* 1914, to *April 26 1920*, that I last saw her alive on *April 26 1920*, and that death occurred, on the date stated above, at *8 P* m. The CAUSE OF DEATH* was as follows:*Myocardial Infarction*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Stephen M. M. D.*

19 Address

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

1142689

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 832. Edmondson Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 832 Edmondson Ave ST. WARD. (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Geo W. D. Donnell

6 DATE OF BIRTH (month, day, and year)

Sept 8 - 1846

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

or min.

13

7

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Enoch F. Hook

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Margaret Charlotte

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Geo. W. Donnell
832. Edmondson Ave

15

Filing

APR 29 1920

ROBERT R. KRAUTER Registrar

Notary Public State

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 28 1920

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1920, to April 28, 1920, that I last saw him alive on April 28, 1920, and that death occurred, on the date stated above, at 4. a. m. The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds. 18

CONTRIBUTORY (Secondary)

Industrial Disturbance

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 832 Edmondson Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) J. Thomas Nelson, M. D.

19 (Address) 1001 N. Tenth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL

New Cathedral 4-30-1920

20 UNDERTAKER ADDRESS 51 N. Tenth Ave

W. B. Manning Schrodte

TION is very important. See instructions on back of certificates.

D42690

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D42690
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Vincent's Infant Asylum WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Catharine Elizabeth McSorley(Residence in Baltimore: No. 1401 Division St.)St.; 2 yrs., 2 mos., 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <u>Female</u>	4-COLOR OR RACE <u>White</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <u>Single</u>
6-DATE OF BIRTH, <u>Feb.</u> <u>1st</u> <u>1920</u> (Month) (Day) (Year)		
7-AGE, <u>2</u> <u>22</u> <u>ds.</u>yrs.....mos.....ds.		IF LESS than 1 day,hrs. or.....min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work..... <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)..... <u>sd</u>		
9-BIRTHPLACE, (State or Country), <u>Balt. Md.</u>		
PARENTS.	10-NAME OF FATHER, <u>David Ford</u>	
	11-BIRTHPLACE OF FATHER (State or Country), <u>America</u>	
	12-MAIDEN NAME OF MOTHER <u>Anna McSorley</u>	
	13-BIRTHPLACE OF MOTHER (State or Country), <u>America</u>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) St. Vincent's Infant Asylum(Address) 1401 Division St.

15-

APR 29 1920

ROBERT E. BRADEN

Filed..... 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April, 28, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1st 1920, to April 28th 1920, that I saw her alive on April 28th 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition
.....
..... (Duration).....yrs.. 2.....mos.....ds.
CONTRIBUTORY.....Marasmus
(Secondary)
..... (Duration).....yrs.....mos.....ds.
(Signed) Chas. H. H. H. M. D.
....., 191... (Address) 1501 McSorley

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

CathedralApril 29 1920

20-UNDERTAKER

ADDRESS

William T. Foley & Sons 827 North

D42691

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

St.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

15-

Filed

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

and that said deceased came to death

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

(Coroner)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death....yrs....mos....ds. State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms important. See instructions on back of certificate.

D42692

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42692

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Franklin St. Hospital* ST. *15* WARD)2-FULL NAME *Mary A. Melville*(Residence in Baltimore: No. *1619 4 Monroe*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. *50* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female white

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

unknown, 1
(Month) (Day) (Year)

7-AGE,

57 yrs. mos. ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Housework at home*

9-BIRTHPLACE, (State or Country),

Ireland

10-NAME OF FATHER,

Ferdinand Hogan

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Mary Cummings

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. Melville*(Address) *1619 4 Monroe St.*

15-

APR 29 1920

Filed.

101.

ROBERT B. KRAUTER

BIRTH PERMIT Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 27, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquest*, au-*Inquest* find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows

Acute nephritis, following chronic nephritis.(Duration) yrs. mos. ds. *4*

CONTRIBUTORY (Secondary)

Uræmia(Duration) yrs. mos. ds. *4*(Signed) *James M. Penbury* M. D.

(Coroner)

April 28, 1920 (Address) *800 E. Chase St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death *Franklin St. Hospital* In the *50* yrs. mos. ds. State *50* yrs. mos. ds.Where was disease contracted, if not at place of death? *On Street Car*Former or usual residence *1619 4 Monroe St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Annapolis Md April 30, 1920

20-UNDERTAKER

ADDRESS

Charles Bailey & Sons 182 N. Portland

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *22* WARD)2-FULL NAME *Ruby Di Blasi*(a) RESIDENCE. NO. *806 Hanover* ST. *51* WARD.

(Usual place of abode)

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*F.**W.**S.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Mar. 2 3-1920*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Italy*10 NAME OF FATHER *Rosario Di Blasi*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Italy*12 MAIDEN NAME OF MOTHER *Vincenza Ferragamo*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Italy*

14

Informant (Address)

15

Filed

APR 29 1920

ROBERT R. FLAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr 15 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*March 23, 1920, to Apr 15, 1920,*that I last saw her alive on *Apr 15, 1920,*and that death occurred, on the date stated above, at *5 a.m.*

The CAUSE OF DEATH* was as follows:

congestive atelectasis(duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *F. C. Mamm*, M. D.19 (Address) *St. Joseph's Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITAL

19

20 UNDERTAKER

Commissioner Health.

ADDRESS

APR 26 1920

W. WOODALL

See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42691

CERTIFICATE OF DEATH.

64

D42691

PLACE OF DEATH

CITY OF BALTIMORE (No. 222 St. Paul St. St.:

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mollie E. Farrell. (C)

(Residence in Baltimore: No. 222 St. Paul St.

35 St.; yrs., mos. --- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female. 4-COLOR OR RACE, Colored. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married. (Write the word.)

6-DATE OF BIRTH, January 16th, 1868, 1 (Month) (Day) (Year)

7-AGE, 53 yrs., 3 mos., 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Lexington, Va.

10-NAME OF FATHER, Simon Jones. (C) 11-BIRTHPLACE OF FATHER (State or Country), Lexington, Va. 12-MAIDEN NAME OF MOTHER, Harriet Woodford. (C) 13-BIRTHPLACE OF MOTHER (State or Country), Lexington, Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) William Farrell. (C) husband. (Address) 222 St. Paul St.

15- APR 29 1920 ROBERT E. TRAUTER Registrar. Filed 191.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 28th, 1920, 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signature) Otto M. Remhard, M.D. (Coroner.) Apr. 28th 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery. DATE OF BURIAL, May 1, 1920.

20-UNDERTAKER, John H. Chase & Son. ADDRESS, 1400 Mosker.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter statement of OCCUPATION in plain terms. See instructions on back of certificate.

D42696

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42696

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Heckel and Entaw* ST. *127* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Augusta Heckel*(a) RESIDENCE. No. *Heckel and Entaw* ST. *127* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *30* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Agnes Heckel

6 DATE OF BIRTH (month, day, and year)

Feb. 4th 1880

7 AGE

40

Years

Months

2

Days

23

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Contractor

(b) General nature of industry, business, or establishment in which employed (or employee)

Building construction

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Gotlieb Heckel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Wurttemberg Germany

12 MAIDEN NAME OF MOTHER

Mary Rothkopf

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Maryland

14

Informant (Address)

*Agnes Heckel
Baltimore Md.*

15

Filed

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 27 1920

17

I HEREBY CERTIFY, That I attended deceased from

*April 1, 1920, to April 27, 1920.*that I last saw him alive on *April 27 1920*and that death occurred, on the date stated above, at *3:40 P. M.*

The CAUSE OF DEATH* was as follows:

Multiple neuritis. (Cause unknown)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Permeable (unknown)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *spec. blood smears*(Signed) *Claus Grimm*, M. D.19 (Address) *4706 Harvard Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Jerusalem Cemetery**May 1st 1920*

20 UNDERTAKER

ADDRESS

*Frank L. Schuchman**Baltimore*

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

APR 29 1920

D42697

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Royal Oak Ave ST.; 28 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Naomi S. Pedderson(Residence in Baltimore: No. Royal Oak Ave St.; 25 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE, White 5-SINGLE, Widow
(Write the words)6-DATE OF BIRTH, July 26th, 1842
(Month) (Day) (Year)7-AGE, 47 yrs., 9 mos., 2 ds. If LESS than 1 day, — hrs. or — min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), Columbus Ohio10-NAME OF FATHER, John W. Pedderson11-BIRTHPLACE OF FATHER (State or Country), Id.12-MAIDEN NAME OF MOTHER, Sarah Childs13-BIRTHPLACE OF MOTHER (State or Country), Id.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Pedderson(Address) Royal Oak Ave. Myrtle

15- Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 28th, 1900
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Apr 24th 1900, to Apr 28th 1900, that I saw him alive on Apr 28th 1900, and that death occurred, on the date stated above, at 12 m. The CAUSE OF DEATH* was as follows:
Natural & Accidental
dilatation of heart(Duration) — yrs., 4 mos., — ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs., — mos., — ds.(Signed) Chas. C. Brown M. D.Apr 29th, 1900. (Address) 44 S. V. P. Relationship

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Quint RidgeDATE OF BURIAL, April 28th, 190020-UNDERTAKER, EdisonADDRESS, 1723 W. Gay St.

important. See instructions on back of certificate.

N.B.-Every item of information should be carefully supplied. AGE should be stated in years, months and days. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

D42698

CERTIFICATE OF DEATH

REGISTERED NO. C

D42698

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Park Heights Ave & ...*)

2-FULL NAME

(Residence in Baltimore: No. *Park Heights Ave & ...*)

ST. *...* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

M.

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6-DATE OF BIRTH

May 2nd, 1914

7-AGE

6 yrs. 11 mos. 27 ds.

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Schoolboy

9-BIRTHPLACE (State or country)

Baltimore

10-NAME OF FATHER

Edgar L. Heaven

11-BIRTHPLACE OF FATHER (State or country)

Baltimore

12-MAIDEN NAME OF MOTHER

Frances L. Tyler

13-BIRTHPLACE OF MOTHER (State or country)

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Helen J. Burbank

(Address)

Richmond Ea

15.

Robert P. Harrison

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

April 28, 1920

17- I HEREBY CERTIFY. That I attended deceased from

Apr 21, 1920 to Apr 28, 1920

that I saw him alive on *Apr 28, 1920*

and that death occurred, on the date stated above, at *10* m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) *8* yrs. *8* mos. *8* ds.

Contributory (SECONDARY)

(Duration) *8* yrs. *8* mos. *8* ds.

(Signed)

W. S. McElroy M. D.

(Address) *37 W. Preston St.*

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *...* yrs. *...* mos. *...* ds. State *...* yrs. *...* mos. *...* ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green Mount

Apr 30, 1920

20-UNDERTAKER

ADDRESS

John O. Mitchell

APR 29 1920

Burial Permit Clerk REGISTRAR

D42699

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42699

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Md. General Hospital

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John Edward Christopher

(a) RESIDENCE. NO.

805 Gorsuch Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

39 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

48 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 3 - 1872

7 AGE

48

Years

Months

2

Days

26

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

Adams ex Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Dorchester Co Md

10 NAME OF FATHER

John E. Christopher

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

May E. Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Nettie Christopher 805 Gorsuch Ave

15

FEB 9 1920

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 29 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug. 27, 1919, to April 29, 1920, that I last saw him alive on April 29, 1920, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Septic infection with chronic diffuse peritonitis.

Severe (duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Anemia

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

805 Gorsuch Ave.

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Wassermann, urinalysis -

(Signed)

R. E. Wright

M. D.

4/29, 1920 (Address)

Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lorraine Cemetery

May 1 1920

20 UNDERTAKER

ADDRESS

John Mitchell

120 N. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

Burial Permit Clerk

D42700

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH USA General Hospital No.2,

REGISTERED NO. C

CITY OF BALTIMORE: (No. Fort McHenry, Md.

ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Purdy, Retired Army Captain.

(Residence in Baltimore: No. 1322 Eutaw Place, Baltimore, Md.

St.: 9 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male	4-COLOR OR RACE. White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married (Write the word.)
----------------	---------------------------	--

6-DATE OF BIRTH. Unknown (Month) (Day) (Year)	7-AGE. 46 yrs., mos. da. It LESS than 1 day, hrs. or min.
---	---

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).	Retired Army Captain
--	----------------------

9-BIRTHPLACE. (State or Country),	Ind.
--------------------------------------	------

PARENTS.	10-NAME OF FATHER, Unknown
	11-BIRTHPLACE OF FATHER (State or Country), Unknown
	12-NAME OF MOTHER (State or Country), Mrs. Clarence Purdy, Wife of 1322 Eutaw Place, Balto., Md.
	13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Munnie A. Purdy (Address) 1322 Eutaw Place
--

15-APR 9 1920 Robert P. Harrison, Burial Permit Clerk
--

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 28, 1920, 191...

17- I HEREBY CERTIFY, That I attended deceased from April 18, 1920, to April 28, 1920, that I saw him alive on April 28, 1920, and that death occurred, on the date stated above, at 11:20 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia lobar left lower, rt. lower, middle and upper lobes. Pneumococcus Type IV. Pneumococcus vaccine no record-Pt. stated not given.

CONTRIBUTORY (Secondary)

(Signed) Walter N. Mercer Walter N. Mercer Capt. Med. Corps. U. S. A. Apr. 28, 1920 (Address) Ft. McHenry, Md.
--

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
--

At place of death yrs. mos. da. In the State yrs. mos. da.
--

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park	DATE OF BURIAL, April 24 1920
--	-------------------------------

20-UNDERTAKER, John O'Leary	ADDRESS, 1200 N. Taylor
-----------------------------	-------------------------

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42701

CERTIFICATE OF DEATH

REGISTERED No. C

D42701

PLACE OF DEATH

CITY OF BALTIMORE (No.

ST. 8 WARD)

2-FULL NAME

(Residence in Baltimore: No.

St. 7 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE,

MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Month Day Year
11/20/1872

7 AGE

48 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Salver

9 BIRTHPLACE (State or country)

Balto. Md.

10 NAME OF FATHER

Alexander Brooker

11 BIRTHPLACE OF FATHER (State or country)

H. Maryland

12 MAIDEN NAME OF MOTHER

Mary Johnson

13 BIRTHPLACE OF MOTHER (State or country)

H. Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Charlotte Ash

1707 N. Dallas St.

15

Robert P. Harrison,

Burial Permit Clerk,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 27, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from

April 12, 1920, to April 27, 1920.

that I saw him alive on April 26, 1920.

and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Barrenness of stomach

(Duration) yrs. 6 mos. ds.

Contributory (SECONDARY)

Exhaustion

(Duration) yrs. 7 mos. ds.

(Signed)

April 28, 1920.

(Address) Dr. E. J. Kelly

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sanary cemetery

4/30, 1920

20 UNDERTAKER

ADDRESS

Edw. Ringgold 1463 Carey

APR 29 1920

D42702

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42702

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2120 W Saratoga St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs. Rosina Barbara Grathwol.

(a) RESIDENCE

No. 2140 - W Saratoga ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

5.

mos.

78

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Leopold Grathwol

6 DATE OF BIRTH (month, day, and year)

Apr 6 - 1858

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.

67

167

0

22

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

House Keeper

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

New Haven

10 NAME OF FATHER

Jacob Stephens

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

no

12 MAIDEN NAME OF MOTHER

Rose Stephens

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Germany

14

Informant
(Address)Albert A. Grathwol,
2017-5th Ave. Troy, N.Y.

APR 29 1920

Burial Permit Clerk

Registrar

Robert P. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 28 1920

17

HEREBY CERTIFY, That I attended deceased from
April 27, 1920, to April 28, 1920,
 that I last saw him alive on April 28, 1920,
 and that death occurred, on the date stated above, at 5:20 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)

Cerebral Hemorrhage

(duration) 2 yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward

Kewolahan

M. D.

19 (Address)

24 Fulton St

*State the Disease Causing Death, or in deaths from Violent Causes,
 state (1) Means and Nature of Injury, and (2) whether Accidental,
 Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Bridgeport - Conn

Apr 30 1920

20 UNDERTAKER

W. J. Tucker & Sons

ADDRESS

N.Y.C.

D42703

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42703

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital 16* WARD)

2-FULL NAME

Rosia Lucinda Lumpkin

(a) RESIDENCE. NO.

826 N. Carrollton Ave ST. WARD. *16*
(Usual place of abode)
Length of residence in city or town where death occurred *52* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Married</i>
5a If married, widowed, or divorced HUSBAND of (or) WIFE of <i>Dr. J. M. Lumpkin</i>		
6 DATE OF BIRTH (month, day, and year) <i>Dec 27-1867</i>		
7 AGE	Years <i>52</i>	Months <i>4</i>
	Days <i>1</i>	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md

10 NAME OF FATHER

Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ohio

12 MAIDEN NAME OF MOTHER

Baroline Uber

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

*Dr. J. M. Lumpkin
826 N. Carrollton Ave**Robert F. Harrison,*

15

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 28 1920*

17 I HEREBY CERTIFY, That I attended deceased from *April 15th*, 1920, to *April 28*, 1920, that I last saw him alive on *April 28*, 1920, and that death occurred, on the date stated above, at *2:35 P. m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach(duration) yrs. *4(?)* mos. ds.

CONTRIBUTORY (Secondary)

Acute Cardiac Dilatation
(duration) yrs. — mos. — ds.18 Where was disease contracted if not at place of death? *826 N. Carrollton Ave*Did an operation precede death? *Yes* Date of *April 26th 1920*Was there an autopsy? *No*What test confirmed diagnosis? *Laboratory findings + operation*(Signed) *William B. Dalton*, M. D.4/28/1920 Address) *Maryland General Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Druid Ridge**Apr 30 1920*

20 UNDERTAKER

ADDRESS

*Wm J. Tuckner & Sons**N. & Pa*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

APR 29 1920

D42701

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42701

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Hawdon Park* ST. *15* WARD)2-FULL NAME *William Graham*(Residence in Baltimore: No. *3027 N. North Ave*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *Feb 9*, 1865
(Month) (Day) (Year)7-AGE, *55* yrs. *2* mos. *16* da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) *Montreal Canada*10-NAME OF FATHER, *George Graham*11-BIRTHPLACE OF FATHER (State or Country) *Unknown*12-MAIDEN NAME OF MOTHER *Jessie McElroy*13-BIRTHPLACE OF MOTHER (State or Country) *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sarah A. Graham*(Address) *3027 N. North Ave*

15-

*Robert P. Harrison,*Filed *APR 10 1920*

101

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 27*, 19*20*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heard shot wound in head
suicide
(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Signed) *E. E. Smith*

(Coroner)

4/28, 19*20*(Address) *910 Leggett St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Hoodlawn*DATE OF BURIAL, *Apr 30*, 19*20*20-UNDERTAKER *Wm J. Tickner & Son*ADDRESS *N. Ga*

D42705

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42705

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Little Sisters of the Poor

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.; *10* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

John J. Anderson

(Residence in Baltimore: No.

*Little Sisters of the Poor*St.; *Life* yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5--SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Feb 20 - 1857

(Month)

(Day)

(Year)

7-AGE,

69 yrs., *2* mos., *8* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

John J. Anderson

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Elizabeth Williams

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THIS ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Sister Benedict

(Address)

Little Sisters of the Poor

15-

Robert P. Harrison,

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 28th, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

to record 191....., to 191.....,that I saw him alive on *April 25* 191.....,and that death occurred, on the date stated above, at *1:15 P.m.*

The CAUSE OF DEATH* was as follows:

*Chronic interstitial Nephritis**Unknown* (Duration).....yrs.....mos.....ds.CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....*J. Warner*.....M. D.*April 29, 1920* (Address).....*1133 Valley St*.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. *2* mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cathedral *April 30, 1920*

20-UNDERTAKER ADDRESS

H. C. Wiedefeld 914 Green Mt

CAUSE OF DEATH is important. See instructions on back of certificate.

APR 29 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42706

D42706

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Med. Seal Hospital ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Josephine Donnelly(a) RESIDENCE. No. 123 Belvedere Ave. ST. 27 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 3 mos. 19 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. L. Donnelly6 DATE OF BIRTH (month, day, and year) Jan. 9 1858

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 62 3 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)10 NAME OF FATHER Joseph Green11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)12 MAIDEN NAME OF MOTHER Anna Greenwell13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14

Informant Geo. L. Donnelly
(Address) 123 Belvedere Ave.15 Robert P. Harrison

Registrar

APR 9 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1920

17

HEREBY CERTIFY, That I attended deceased from March 2, 1920, to April 28, 1920.that I last saw her alive on 4/28, 1920, and that death occurred, on the date stated above, at 8:00 m.

The CAUSE OF DEATH* was as follows:

Cancerous of Breast(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.18 Where was disease contracted if not at place of death? HomeDid an operation precede death? Yes Date of 3/4/20Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Oliver G. Smith, M. D.19 (Address) Med. Seal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New CathedralMay 1st 1920

20 UNDERTAKER

ADDRESS

Geo W Little531 N. Fremont

HEALTH DEPARTMENT—CITY OF BALTIMORE

042707

042707

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *619 E 34 St.* St.: *4* WARD)

2-FULL NAME

Abraham Brown

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *725 W Fayette* St.: yrs., - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

March 27, 1864
(Month) (Day) (Year)

7-AGE,

56 yrs. *1* mos. *1* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

Salesman

9-BIRTHPLACE, (State or Country),

Baltimore Co. Md

10-NAME OF FATHER,

Abraham Brown

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore Co. Md

12-MAIDEN NAME OF MOTHER

Sarah

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Fletcher H. Long

(Address)

619 E 34 St

15-

Robert P. Harrison,

Burial Permit Clerk,

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 28, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained (Inquest, au-

opsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epic Sports Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Wm. J. Riley* M. D.

(Address) *4-28-20*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Baltimore

DATE OF BURIAL,

April 30 1920

20-UNDERTAKER

Geo W Little

ADDRESS

531 St. Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D42709

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42709

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1452 Henry*ST. *24* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *1452 Henry*

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *35* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widower*

5a If married, widowed, or divorced

HUSBAND of *the late Annie Garvey*
(or WIFE of)6 DATE OF BIRTH (month, day, and year) *March 15, 1855*7 AGE Years *65* Months *1* Days *13* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Ireland*
(State or country)10 NAME OF FATHER *John Garvey*11 BIRTHPLACE OF FATHER (city or town) *Ireland*
(State or country)12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) *Ireland*
(State or country)

14

Informant *Annie Noon*
(Address) *1452 Henry St.*

15

Filed *APR 29 1920*

19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 28 1920*

17

I HEREBY CERTIFY, That I attended deceased from *April 23*, 19*20*, to *April 28*, 19*20*, that I last saw him alive on *April 28*, 19*20*.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Myocarditis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *7*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *No*(Signed) *M. B. Flynn*

M. D.

4/29, 1920 Address *274 Sullivan St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cem.

DATE OF BURIAL

April 30 1920

20 UNDERTAKER

M. B. Flynn

ADDRESS

1822 Light

CAUSE OF DEATH in plain terms, so that a layman can understand. See instructions on back of certificates.

D42710

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42710

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Etzel(a) RESIDENCE. NO. 2218 Christian St. ST. Life WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced
HUSBAND of Rosey
(or) WIFE of Nickie Unknown6 DATE OF BIRTH (month, day, and year) 1898 July 5

7 AGE

Years

Months

Days

If LESS than
1 day,hrs.
ormin.22224

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workClerk(b) General nature of industry,
business, or establishment in
which employed (or employer)Unknown

(c) Name of employer

Unknown9 BIRTHPLACE (city or town)
(State or country)Baltimore
Maryland

10 NAME OF FATHER

John Etzel11 BIRTHPLACE OF FATHER (city or town)
(State or country)Germany12 MAIDEN NAME OF MOTHER Annie Urban13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Bohemia14 Informant Hospital Records

(Address)

M.T.H.

15

APR 29 1920

Robert A. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29, 1920

17

I HEREBY CERTIFY, That I attended deceased from
March 21, 1920, to April 29, 1920,that I last saw him alive on April 28, 1920,and that death occurred, on the date stated above, at 6.25 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) yrs. 5 mos. 15 ds.CONTRIBUTORY
(Secondary)(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted

if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum(Signed) George R. Wilkerson, M. D.4-29-20 (Address) Municipal Tbc. Hospital*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

West Catholic Cemetery May 1 1920

20 UNDERTAKER

ADDRESS

Liston P. Friesellbaugh 2620 St
Paul St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42711

CERTIFICATE OF DEATH.

28 ✓
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1840 Wilhelm ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1840 Wilhelm St.; 29 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M. 4-COLOR OR RACE, W. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

6-DATE OF BIRTH, Aug 29, 1874 (Month) (Day) (Year)

7-AGE, 45 yrs., 7 mos., 29 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Merchant Cutter
(b) General nature of industry, business, or establishment in which employed (or employer), 676

9-BIRTHPLACE, (State or Country), Va.

10-NAME OF FATHER, Wm. Graham

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER, Mary McPherson

13-BIRTHPLACE OF MOTHER (State or Country), Penn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie T. Graham

(Address) 1840 Wilhelm St.

15-APR 30 1920 ROBERT E. KRAUTER

Filed..... 191. DEPUTY CLERK

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 27, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 15 1920, to April 27 1920, that I saw him alive on April 25 1920, and that death occurred, on the date stated above, at 6:29 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs., mos. ds.

CONTRIBUTORY, Coracal Asthma (Secondary)

(Duration) 6 yrs., mos. ds.

(Signed) Edw. W. W. W. M. D.

(Address) 24 N. Fulton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, April 30, 1920

20-UNDERTAKER, John J. Fields 1200 N. Lombard

important. See instructions on back of certificate.

Schmelyum
HEALTH DEPARTMENT—CITY OF BALTIMORE

D42712

CERTIFICATE OF DEATH.

170 D42712

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2661 Lehman* ST.: *20* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Bertha Bell Schmelyum*(Residence in Baltimore: No. *2661 Lehman* St.: *14* yrs., *One* mos., *4* ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)

6-DATE OF BIRTH, *March 24th, 1906*
(Month) (Day) (Year)

7-AGE, *14 yrs., One mos., 4 ds.* If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *School girl*
(b) General nature of industry, business, or establishment in which employed (or employer), *ooo*

9-BIRTHPLACE, (State or Country), *Baltimore Maryland*

10-NAME OF FATHER, *Henry J Schmelyum*

11-BIRTHPLACE OF FATHER (State or Country), *Baltimore Md.*

12-MAIDEN NAME OF MOTHER *Lena Brummer*

13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lena Schmelyum*(Address) *2661 Lehman ST*

15-APR 30 1920 ROBERT E KRAUTER
Filed 101 Burial Permit Registered

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 28th, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *March 20th 1920*, to *April 28th 1920*, that I saw her alive on *April 28th 1920*, and that death occurred, on the date stated above, at *1-15 P. m.* The CAUSE OF DEATH* was as follows:

Urasmia
(Duration).....yrs. *2*...mos.ds.

CONTRIBUTORY *Thrombolytic nephritis*
(Secondary)
(Duration).....yrs. *10*...mos.ds.
(Signed) *James H. Fargo* M. D.
April 28th 1920 (Address) *446 Baltimore St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs.mos.ds. In the State yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park Cem* DATE OF BURIAL, *April 30, 1920*

20-UNDERTAKER, *Robert Brooks & Son* ADDRESS *17 S Calhoun st*

important. See instructions on back of certificate.

D42713

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167

D42713

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *420 S Duncan St.*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Kazmiera Kurylo (KAZMIERA KURYLO)(Residence in Baltimore: No. *420 S Duncan*)St.: yrs. *8* mos. *8* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Bel.*

6-DATE OF BIRTH

Aug. 20, 1918
(Month) (Day) (Year)

7-AGE

1 yrs. *8* mos. *8* ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*None*

9-BIRTHPLACE, (State or Country),

Baltimore Md

10-NAME OF FATHER,

John Kurylo

11-BIRTHPLACE OF FATHER (State or Country),

Poland

12-MAIDEN NAME OF MOTHER

Helen Powiatowicz

13-BIRTHPLACE OF MOTHER (State or Country),

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Kurylo

(Address)

420 S. Duncan

15-

Filed

APR 30 1920

ROBERT E. BAUTER

Burial Permitted

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

April 29, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, (request, autopsy or inquiry.)

thereof and from the evidence obtained, I held an inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns scalds while playing with matches
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Wm. J. Gentry* M. D.

(Coroner.)

(Address) *1118 E. Carey*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Holy Rosary**Apr. 30, 1920*

20-UNDERTAKER

ADDRESS

William Galford, 1118 E. Carey

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42711

D42711

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *Westminster 2nd* ST. *Westminster Md.*

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

9

ds.

How long in U. S., if of foreign birth?

59 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 18 1860

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*59**11**9*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

house work

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Francis Reese Westminster Md.

15

APR 30 1920

ROBERT E. KRAUTER Registrar

Burial Permit Order

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 29 1920

17

I HEREBY CERTIFY, That I attended deceased from

*4/12*19 *20*to *4/29*19 *20*

that I last saw him alive on

*4/24*19 *20*

and that death occurred, on the date stated above, at

11.55 p.m.

The CAUSE OF DEATH* was as follows:

Gastric Canceroma

CONTRIBUTORY (Secondary)

unknown

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Yes

Date of

4/27/20

Was there an autopsy?

No

What test confirmed diagnosis?

Operation

(Signed)

4/29/20

(Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Westminster Md.**April 2 1920*

20 UNDERTAKER

W. Maurice Roulton

ADDRESS

2238 W. Ind. ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Frances Gross
HEALTH DEPARTMENT—CITY OF BALTIMORE

D42715

CERTIFICATE OF DEATH.

64 D42715

PLACE OF DEATH

CITY OF BALTIMORE (No. *2443 Edchi*)

ST. *13* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Francis Gross

(Residence in Baltimore: No. *2443 Edchi St*)

68 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

Unknown

1838

(Month) (Day) (Year)

7-AGE,

82

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country), *Md*

10-NAME OF FATHER,

Benjamin Gross

11-BIRTHPLACE OF FATHER,

Md

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER,

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. D. Jones

(Address)

2443 Edchi St

APR 30 1920

ROBERT E. KRAUTER

101

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April

28, 1920

(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the

remains described above, held an

Inquest

thereon and from the evidence obtained by said

Inquest

find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

John H. Brown

April 29 1920 (Address) *3632 Roland St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Whitman

May 1st 1920

20-UNDERTAKER

ADDRESS

Charles Wright 1364 Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42716

CERTIFICATE OF DEATH.

91

D42716

1-PLACE OF DEATH

CITY OF BALTIMORE: (No

803 W Franklin

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Bernice Young

(a) RESIDENCE. No.

803 Franklin

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Fem

4 COLOR OR RACE

Blk

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov 22 - 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Bernard Young

11 BIRTHPLACE OF FATHER (city or town) (State or country)

St Mary County Md

12 MAIDEN NAME OF MOTHER

Carrie Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Carrie Young 803 W Franklin St

15

APR 30 1920

ROBERT E. KRAUTER

Sanitary Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 28th 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr 27th 1920, to Apr 28th 1920, that I last saw him alive on Apr 27th 1920,

and that death occurred, on the date stated above, at 11:05 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gustav Holman, M. D.

19 (Address) 1516 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Peter's

Apr 30 1920

20 UNDERTAKER

ADDRESS

Bernice Young 364 N. Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D42718

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D42718

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Hannah Burger

(a) RESIDENCE. NO.

1330 O'neal

ST.: _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

40 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofIgnatius C. Burger

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.60

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Ireland

10 NAME OF FATHER

Patrick O'Keefe

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Hannah Kuller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant

Mrs. Mary Mc Carthy

(Address)

2914 St Paul St

15

Filed

APR 30 1920ROBERT A. TRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 29 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 25, 1920, to April 29, 1920,that I last saw her alive on April 29, 1920,and that death occurred, on the date stated above, at 8:45 A. M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency(duration) _____ yrs. _____ mos. 3 ds.CONTRIBUTORY
(Secondary)Sarcoma of cervical gland(duration) 1 yrs. _____ mos. _____ ds.

18 Where was disease contracted

if not at place of death?

UnknownDid an operation precede death? yes Date of Nov 20-1919Was there an autopsy? noWhat test confirmed diagnosis? Microscopic findings(Signed) Daniel Miller M. D., 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

19

20 UNDERTAKER

ADDRESS

Chas. D. Evans & Son 118 W. Mt Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D42719

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42719

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1841-E Biddle ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John S. Dersch

(a) RESIDENCE. NO.

1841-E Biddle ST. WARD. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

Catherine A. Dersch

6 DATE OF BIRTH (month, day, and year)

4/10/1855

7 AGE

65 Years Months Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Himself

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

John S. Dersch

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Bunde

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant (Address)

Mrs. C. Dersch 1841-E Biddle St.

15

APR 30 1920 ROBERT B. BAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1920

17 I HEREBY CERTIFY, That I attended deceased from February 1915, to April 26, 1920, that I last saw him alive on April 25, 1920, and that death occurred, on the date stated above, at 10 p. m. The CAUSE OF DEATH* was as follows:

Myocarditis

CONTRIBUTORY (Secondary) Emphysema of Lungs (duration) 5 yrs. mos. ds. (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) W. C. Sandrock M. D.

7.4.1920 (Address) 1242 N. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park Cem.

DATE OF BURIAL

4/30/1920

20 UNDERTAKER

George J. Ruth

ADDRESS

1735 - Harbor Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42720

CERTIFICATE OF DEATH.

120 D42720
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1818 N. Caroline ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1818 N. Caroline St. St.; 70 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-STATUS.
MARRIED, WIDOWED,
OR DIVORCED.
(Write the word.)
Widowed

6-DATE OF BIRTH,

....., 1.....
(Month) (Day) (Year)

7-AGE.

86

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Retired 100
Hammif9-BIRTHPLACE,
(State or Country),

Ireland

PARENTS.

10-NAME OF FATHER,

James Kelley

11-BIRTHPLACE OF FATHER
(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Annis Doory

(Address) 1818 N. Caroline St.

15-

APR 30 1920 101... ROBERT F. LEAFTER

Registrar.

Serial Permit 6124

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

April 28th 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Nov 20th 1919, to April 28th 1920,that I saw her alive on April 27th 1920,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Atrial fibrillation
and
Cor. Subtotal Infarct
(Duration) 2 yrs., mos., ds.CONTRIBUTORY
(Secondary)

(Duration) 2 yrs., mos., ds.

(Signed)

J. M. C. Parker M. D.

Apr 30, 1920 (Address) 1114 Calver Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Calver County

DATE OF BURIAL,

May 1st, 1920

20-UNDERTAKER

George J. Ruch

ADDRESS

1735 Hayford Ave

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

042721

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 Hillen ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lucie Fields(a) RESIDENCE. No. 1007 Hillen ST., 5 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 0 ds. How long in U. S., if of foreign birth? 2 yrs. 1 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) May 17, 19147 AGE Years 6 Months 11 Days 12 If LESS than 1 day, hrs. 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)10 NAME OF FATHER Andrew J. Fields11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)12 MAIDEN NAME OF MOTHER Josephine M. Lewis13 BIRTHPLACE OF MOTHER (city or town) M.D.
(State or country)14 Informant Cydney Fields
(Address) 1007 Hillen St.15 APR 30 1920 ROBERT B. LAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 192017 I HEREBY CERTIFY, That I attended deceased from April 27, 1920, to April 29, 1920, that I last saw her alive on April 29, 1920, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Chicken PoxCONTRIBUTORY (Secondary) Gastro-Intestinal System (duration) 3 mos. 1 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? St. Vincent(Signed) [Signature] M.D.4.29.1920 (Address) 827 E. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Vincent Cem.Apr 30 1920

20 UNDERTAKER

ADDRESS

Geo. J. Puth 1735-Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42722

CERTIFICATE OF DEATH

REGISTERED

D42722

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

APR 30 1920

ROBERT E. KRAUTER

BURIAL PLACE REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from March 1918, to April 29 1920.

that I saw her alive on April 29, 1920, and that death occurred, on the date stated above, at 6 a.m. The CAUSE OF DEATH* was as follows:

Mitral stenosis & Myocardial Insufficiency

Contributory (SECONDARY)

(Signed)

April 13, 1920

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death... yrs... mos... ds. State... yrs... mos... ds.
Where was disease contracted?
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42723

CERTIFICATE OF DEATH.

REGISTERED NO. C

D42723

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST. *13* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2233 Mad. Ave* St. *14* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH

March, *1* (Month) (Day) (Year)

7-AGE

75 yrs. mos. ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer). *Self*

9-BIRTHPLACE, (State or Country),

Russia

10-NAME OF FATHER,

Joseph Krupnik

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Rebecca

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Lewis*
(Address) *1411 E. Madison St.*

15-

Filed

APR 30 1920

ROBERT A. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

4-29, *1920* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *4-20* *1920*, to *4-29* *1920*,that I saw her alive on *4-28* *1920*, and that death occurred, on the date stated above, at *2:30* p.m.

The CAUSE OF DEATH* was as follows:

Myocardial infarction
Metastatic carcinoma of the breast

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....(Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

April 29, 1920 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the *14* State.....yrs.....mos.....ds.Where was disease contracted, if not at place of death? *at home*Former or usual residence *2233 Mad Ave*

19-PLACE OF BURIAL OR REMOVAL,

Hebrew Int. Cem.

DATE OF BURIAL,

4-30, *1920*

20-UNDERTAKER

Jack Lewis

ADDRESS

1411 E. Madison St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42724

CERTIFICATE OF DEATH.

120

D42724

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 N. Washington ST.; 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Elizabeth Vlrich

6 DATE OF BIRTH (month, day, and year)

May 18 1858

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

69

1

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

John Vlrich

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Don't know

14

Informant (Address)

George H. Vlrich 1626 N. Washington St.

15

Filed

APR 30 1920

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 18 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 15 1920 to April 28 1920

that I last saw him alive on April 27 1920

and that death occurred, on the date stated above, at 4:45 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Infectious Hepatitis

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William F. Tucker, M. D.

4/28/20 (Address) 1417 W. 1st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Matthews Cem.

May 20

20 UNDERTAKER

ADDRESS

H. Sander Sons

1710 North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D42725

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42725

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. *24* WARD) *77*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary Lang*(a) RESIDENCE. NO. *1400 Andrie St.* ST. *12th* WARD. *12th*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Adam Lang*6 DATE OF BIRTH (month, day, and year) *Feb 4 1878*7 AGE *42* Years *2* Months *20* Days If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Maryland* (State or country)10 NAME OF FATHER *Edw. Morrison*11 BIRTHPLACE OF FATHER (city or town) *Virginia* (State or country)12 MAIDEN NAME OF MOTHER *Rachel Dieter*13 BIRTHPLACE OF MOTHER (city or town) *Virginia* (State or country)14 Informant *Hospital Record* (Address) *26 26*15 Filed *APR 30 1920* REGISTRAR *ROBERT B. KRAUTER* *8100*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 29 1920*17 I HEREBY CERTIFY, That I attended deceased from *April 28, 1920* to *April 29, 1920*, that I last saw her alive on *April 29, 1920*, and that death occurred, on the date stated above, at *6 45 a. m.*

The CAUSE OF DEATH* was as follows:

Hemorrhage into pericardium

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *14 days*18 Where was disease contracted if not at place of death? *At home*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Emile Holthaus* M. D., 19 (Address) *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

DATE OF BURIAL

May 1 1920

20 UNDERTAKER

H. Sander Sons

ADDRESS

1710 Fleet St.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42726

CERTIFICATE OF DEATH.

79

D42726

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2506 St. Paul

ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Collins Blogg

(a) RESIDENCE. NO. 2506 St. Paul

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 16, 1838

7 AGE 86 Years 7 Months 12 Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk, Va., (State or country)

10 NAME OF FATHER Collins Thayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Almira Taft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Massachusetts

14 Informant Edward R. F. Blogg (Address) 2506 St. Paul Street

15 APR 30 1920 ROBERT E. KAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1920

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1920, to April 28, 1920, that I last saw her alive on April 28, 1920, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH was as follows: Acute Cardiac Dilatation Auricular fibrillation

CONTRIBUTORY Myocarditis - Arteriosclerosis Hypertension (duration) 3 yrs. 3 mos. 3 ds. Not known

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of none

Was there an autopsy? no What test conducted? Percussion and auscultation (Signed) H. H. Mays, M. D. 19 (Address) 819 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Druid Ridge Cemetery

DATE OF BURIAL

5/1/20 19

20 UNDERTAKER

Henry W. Mears & Son 805

ADDRESS

N. Calvert St.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1042727

HEALTH DEPARTMENT—CITY OF BALTIMORE

1042727

D42723

CERTIFICATE OF DEATH.

D42723

PLACE OF DEATH

CITY OF BALTIMORE (No.)

FULL NAME

(Residence in Baltimore: No.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M	4-COLOR OR RACE C	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
6-DATE OF BIRTH April 28, 1920 (Month) (Day) (Year)		
7-AGE about 1 yr. 1 mo. 1 da.		If LESS than 1 day. ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE. (State or Country).		
10-NAME OF FATHER.		
11-BIRTHPLACE OF FATHER (State or Country).		
12-MAIDEN NAME OF MOTHER		
13-BIRTHPLACE OF MOTHER (State or Country).		

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

APR 30 1920

101

ROBERT B. KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

April 28, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

John H. Harrison, M. D.
April 29, 1920 (Address) 7632 R. Roadre

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death....yrs....mos....da. State....yrs....mos....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Commissioner Health,

Per. Wm. E. WOODALL.

D42729

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42729

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 Somerset ST. 10 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 820 Somerset St. St.; 1 yrs., 2 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

Feb 18, 1919.
(Month) (Day) (Year)

7-AGE,

1 yrs., 2 mos., 12 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),

City

PARENTS.

10-NAME OF FATHER,

Carroll S. Hoey

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore City

12-MAIDEN NAME OF MOTHER

Bertha Krumman

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alfred A. Bendich(Address) 1228 Patterson Ph.

15-

APR 30 1920 Robert P. Harrison,
191..... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 30, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 27 1920, to April 30 1920,
that I saw him alive on April 29 1920,and that death occurred, on the date stated above, at 1203A m.

The CAUSE OF DEATH* was as follows:

Acute Broncho Pneumonia(Duration).....yrs.....mos.....4 ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Alfred A. Bendich M. D.April 30 1920 (Address) 1228 Patterson Ph.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (i) MEANS OF INJURY; and (s) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the.....yrs.....mos.....ds. State.....

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Bidisonsten May 1, 1920

20-UNDERTAKER

ADDRESS

Geo S Cook North Bayford Ave

N. B.—Every item of information should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42730

D42730

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Johns Hopkins Hospital ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Alfred C. Hudgins

(a) RESIDENCE. NO.

227 Arling Place Norfolk Va

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

+

6 DATE OF BIRTH (month, day, and year)

May 28 - 1860

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

59

4

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Lloyd Hudgins

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Sarah Pratt

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

J. H. R. R. R.

15

Filled

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 29 1920

17

I HEREBY CERTIFY, That I attended deceased from April 16, 1920, to April 29, 1920, that I last saw him alive on April 29, 1920, and that death occurred, on the date stated above, at 10:50 P. M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Eileen of lung

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. B. Bloomfield, M. D.

, 19 (Address) 1014 N. York St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Norfolk Va.

Apr 30 1920

20 UNDERTAKER

ADDRESS

Wm. B. Black 927 N. Broadway

APR 30 1920

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

D42731

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42731

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Josephs Hosp*ST.: *9*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *Belle Harbor Virginia*

(Usual place of abode)

WARD. *Anancock Va*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

6

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec. 25 1896

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*23**4**4*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Ward 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Belle Haven Va

10 NAME OF FATHER

Dr. J. T. B. Hyslop

11 BIRTHPLACE OF FATHER (city or town)

VA.

(State or country)

12 MAIDEN NAME OF MOTHER

Fannie Shown Anderson

13 BIRTHPLACE OF MOTHER (city or town)

VA.

(State or country)

14

Informant (Address)

*Mr. O. S. Hyslop
Middleville, Va.*

APR 30 1920

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 29 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*April 24 1920 to April 29 1920*that I last saw him alive on *April 29 1920*and that death occurred, on the date stated above, at *11 P* m.

The CAUSE OF DEATH* was as follows:

Myocardial infarction(duration) yrs. mos. *1* ds.

CONTRIBUTORY

Acute pulmonary

(Secondary)

Intermittent (duration) yrs. mos. *21* ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

X Ray and Phys. exam.

(Signed)

J. T. Davis

M. D.

Address

St Josephs Hospital

*State the Disease Causing Death or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Anancock Orkney Va.

DATE OF BURIAL

Apr 30 1920

20 UNDERTAKER

Henry Horckley

ADDRESS

1301 E. ...

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42732

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42732

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1101 North Montford Ave* ST. *8* WARD)

2-FULL NAME *John Rapap*

(Residence in Baltimore: No. *1101 77 Montford Ave* ST. *27* yrs. *27* mos. *27* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-~~STATUS~~ *Married*
MARRIED
WIDOWED
OR-DIVORCED
(Write the word)

6-DATE OF BIRTH *June 24, 1860*
(Month) (Day) (Year)

7-AGE *59* yrs. *9* mos. *6* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION *Tailor*
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE *Germany*
(State or country)

10-NAME OF FATHER *John Rapap*

11-BIRTHPLACE OF FATHER *Germany*
(State or country)

12-MAIDEN NAME OF MOTHER *Shaw*

13-BIRTHPLACE OF MOTHER *Germany*
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *L. Walter*

(Address) *1101 77 Montford Ave*

15- *Robert P. Harrison,*

Barrie I. Permitt Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *April 30, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *February 1st, 1920* to *April 30th, 1920*, that I saw him alive on *April 29th, 1920*, and that death occurred, on the date stated above, at *6 A* m. The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) yrs. *6* mos. ds.

Contributory (SECONDARY) *Exhaustion*

(Duration) yrs. mos. *7* ds.

(Signed) *P. E. Kelly* M. D.
April 20, 1920 (Address) *311 E. North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Salem* DATE OF BURIAL *April 2, 1920*

20-UNDERTAKER *Wm. Cook* ADDRESS *802 E. North*

D42733

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D42733

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St. 70 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than

1 day, hrs.

or min.?

8-OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employer)

9-BIRTHPLACE
(State or country)10-NAME OF
FATHER11-BIRTHPLACE
OF FATHER
(State or country)12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Robert P. Harrison,

16-

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

1918, to April 29th 1920,that I saw h. a alive on April 27th 1920,

and that death occurred, on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis.

Contributory
(SECONDARY)

(Signed),

April 29, 1920 [Address] 1713 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Green Mount May 1, 1920

20-UNDERTAKER

John Mitchell 1201 N. Fayette

N. E.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42734

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42734

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2008 St. Paul ST.; 17 WARD)

REGISTERED No. C.....

2-FULL NAME Annie S. Blake

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2008 St. Paul St.; 64 yrs., 6 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female4-COLOR OR RACE, White5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH, March 26, 1902

(Month)

(Day)

(Year)

7-AGE, 64 yrs., 6 mos., 3 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... Housewife(b) General nature of industry, business, or establishment in which employed (or employer)..... Food9-BIRTHPLACE, (State or Country), Md10-NAME OF FATHER, Samuel Jarden11-BIRTHPLACE OF FATHER (State or Country), Md12-MAIDEN NAME OF MOTHER Unknown13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank W. Blake(Address) 2008 St. Paul

15-

Robert E. Harrison,Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 29, 1910

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from April 20 1910, to April 29 1910, that I saw her alive on April 28 1910, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia(Duration).....yrs.....mos.....ds. 10CONTRIBUTORY (Secondary) Cardiac & Catarrh(Duration).....yrs.....mos.....ds. 2(Signed) John H. Harrison(Address) 2430 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.....mos.....ds. In theyrs.....mos.....ds. State.....

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mound OlivesDATE OF BURIAL, May 1, 191020-UNDERTAKER John OutchellADDRESS 1201 N. Fayette

COPIES OF DEATH IN PLAIN ENGLISH. See instructions on back of certificate.

D42735

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D42735

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1233 Bayard ST. 71 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Molloch(a) RESIDENCE. NO. 1233 Bayard ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? 47 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Mary Molloch6 DATE OF BIRTH (month, day, and year) Oct 28, 1871

7 AGE

44

Years

Months 6

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labourer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

Glass house

(c) Name of employer

Conroy Lysen

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Henry Molloch

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Elisa Melle

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant
(Address)Mary Molloch
1233 Bayard

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 27 19 20

17

I HEREBY CERTIFY, That I attended deceased from

March 28, 19 20, to Apr 27, 19 20,that I last saw him alive on Apr 20, 19 20,and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Rupture of Aneurysm of
Thoracic Aorta

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Monley Stragg, M. D.Address 729 Belmont Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Andrew's ChurchMay 1 1920

20 UNDERTAKER

ADDRESS 114 N.Brown & Richard Schodsky

APR 30 1920

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement in OCCURRENCE is very important. See instructions on back of certificates.

D42736

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42736

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Marion C. Hastings*(a) RESIDENCE. No. *146 W. Lauvale St.* ST. *2* WARD. *Middleburg Terrace*

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

19

ds.

How long in U. S., if of foreign birth

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Harold Hastings*6 DATE OF BIRTH (month, day, and year) *April 21 - 1880*

7 AGE

Years

Months

Days

If LESS than

*40**7*1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*New Jersey*

10 NAME OF FATHER

*Henry B. Cornwall*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Conn*

12 MAIDEN NAME OF MOTHER

*Mary Hall Porter*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Long Island*

14

Informant
(Address)*2. H. Harris*

15

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 28* 19 *21*

17

I HEREBY CERTIFY, That I attended deceased from

April 9, 19 *20*, to *April 28*, 19 *20*,that I last saw her alive on *April 28*, 19 *20*,and that death occurred, on the date stated above, at *7:30* a. m.

The CAUSE OF DEATH* was as follows:

Myelogenous leukaemia(duration) *1* yrs. *9* mos. — ds.CONTRIBUTORY
(Secondary)*Erysipelas*(duration) *1* yrs. *0* mos. *1* wk.18 Where was disease contracted
if not at place of death?*New Jersey*

Did an operation precede death?

No

Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Yes

(Signed)

Ann Peril Pridgen, M. D.

19

(Address)

Johns Hopkins Hop

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Middlebury Ave**May 1* 19 *20*

20 UNDERTAKER

ADDRESS

*Joseph Harris**221 W. Broadway*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

APR 30 1920

D42732

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42732

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland Penitentiary* ST. *6* WARD)

REGISTERED NO. C

2-FULL NAME

Charles Daniels

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *214 N. Bond*St.; *18* yrs. *10* mos. *17* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.) *married*

6-DATE OF BIRTH,

June - 10 - 1857
(Month) (Day) (Year)

7-AGE,

62 yrs. *10* mos. *17* ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Street 086*
*Vender*9-BIRTHPLACE.
(State or Country),*South Dakota*

10-NAME OF FATHER,

*Nicholas Daniels*11-BIRTHPLACE OF FATHER
(State or Country),*South Dakota*

12-MAIDEN NAME OF MOTHER

*Ananda Robinson*13-BIRTHPLACE OF MOTHER
(State or Country),*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm. F. Harrison*(Address) *Maryland Penitentiary*

15-

Robert P. Harrison,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April - 27 - 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *April - 4 - 1920*, to *April - 27 - 1920*, that I saw him alive on *April - 26 - 1920*, and that death occurred, on the date stated above, at *9 A.* m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis (alcoholic) Tachycardia and Exhaustion - Cardiac Failure(Duration) *3* yrs. *3* mos. *3* ds.CONTRIBUTORY
(Secondary)(Duration) *23* yrs. *3* mos. *3* ds.(Signed) *William F. Schwartz* M. D.*April 27, 1920* (Address) *md. Penitentiary*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *2* yrs. *15* mos. *15* ds. In the State *md.* yrs. *10* mos. *17* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *214 N. Bond St.*

19-PLACE OF BURIAL OR REMOVAL,

Laurel Lane

DATE OF BURIAL,

May 1, 1920

20-UNDERTAKER

Harry A. Godfrey 1725 Orleans St.

CAUSE OF DEATH in plain terms, that may be properly important. See instructions on back of certificate.

APR 30 1920 Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42738

D42738

CERTIFICATE OF DEATH

1-PLACE OF DEATH

2407 E. Hoffman St.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2407 E. Hoffman

ST.:

WARD)

2-FULL NAME

Martin Hamnevald

(a) RESIDENCE. NO.

2407 E. Hoffman

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

45 yrs.

0 mos.

0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Katie Hamnevald

6 DATE OF BIRTH (month, day, and year)

January 19, 1885

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

67

3

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Watchman 062

(b) General nature of industry, business, or establishment in which employed (or employer)

Brewery

(c) Name of employer

Standard Brewing Co.

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Jacob Hamnevald

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Anna Liest

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Katie Hamnevald 2407 E. Hoffman St.

15

APR 30 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

4-29 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 1, 1919, to April 29, 1920,

that I last saw him alive on April 28, 1920,

and that death occurred, on the day stated above, at 12:35 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (Second attack)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cerebral hemorrhage

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Address 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cem.

5-1 1920

20 UNDERTAKER

ADDRESS

A Rohde & Son 600 N. Broadway

D42739

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42739

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Hopkins Hospital* St.: *7*)FULL NAME *Sarah Ann Clark*(Residence in Baltimore: No. *31 Broad Street (Dundalk)* St.: *7* mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

*Sept 12.**1872*

(Month)

(Day)

(Year)

7-AGE

*48**7**18*

da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer)

Housewife

9-BIRTHPLACE,

(State or Country),

Wales

10-NAME OF FATHER,

John Morris

11-BIRTHPLACE

OF FATHER
(State or Country),*Wales*

12-MAIDEN NAME OF MOTHER

Irene Lewis

13-BIRTHPLACE

OF MOTHER
(State or Country),*Wales*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas. S. Clark

(Address)

31 Broad Street

15-

Robert P. Harrison

101

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*Apr**30**1920*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereof and from the evidence obtained by said

(Inquest, au-

topsy, inquiry.) find that said deceased came to death

on the day stated above.

THE CAUSE OF DEATH* was as follows:

*Traumatism fell down**stairs*

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

James G. Miles

(Coroner)

M. D.

4-30-1920 (Address) *4-30-1920*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death yrs. mos. da. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Dundalk Md

19-PLACE OF BURIAL OR REMOVAL,

Louder Park Cem

DATE OF BURIAL,

May 4, 1920

20-UNDERTAKER

H. J. Tiekner & Sons

ADDRESS

*North 4
Canna Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 30 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42740

CERTIFICATE OF DEATH.

28 D42740

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3104 Remington Ave ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 3104 Remington Ave ST. 12 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Allison Tracey

6 DATE OF BIRTH (month, day, and year)

7 AGE 41 Years 9 Months 28 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Elkridge Md (State or country)

10 NAME OF FATHER Benj F. Bryan

11 BIRTHPLACE OF FATHER (city or town) Elkridge Md (State or country)

12 MAIDEN NAME OF MOTHER Sallie A Baker

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant James A Tracey (Address) 3104 Remington Ave

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1919, to Apr 29, 1920, that I last saw her alive on Apr 28, 1920, and that death occurred, on the date stated above, at 1 P. m. The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage (duration) 10 minutes (Secondary) Pulmonary tuberculosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum (Signed) M. D. (Address) 37 W. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Melville Cem. Elkridge May 2, 1920

20 UNDERTAKER ADDRESS Wm J. Tricketts R. P.

APR 30 1920

Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D42741

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42741

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1738 N. Gayon ST.; 15 WARD)

2-FULL NAME

Robert L. Bradford

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 1738 N. Gayon ST., 15 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Wht 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 17, 1854

7 AGE Years 61 Months 11 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer None

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER James Bradford

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Rachel Lawson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mrs Mary J. Bradford (Address) 1738 N. Gayon St

15 Robert L. Bradford Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 29th 1920

17 I HEREBY CERTIFY, That I attended deceased from Apr. 26, 1920, to Apr. 27, 1920, that I last saw him alive on Apr. 29, 1920, and that death occurred, on the date stated above, at 520 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis
& Meckel's Div.

(duration) yrs. mos. ds. CONTRIBUTORY Great Meckel's Div. to (Secondary) no non-infectious (duration) mos. ds. Meckel's Div.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatic

(Signed) Edw. M. D. (Address) 1605 N. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cem.

May 3, 1920

20 UNDERTAKER

Nancy W. Ehlert

ADDRESS

W. North av

APR 30 1920

Burial Permit Clerk. Registrar

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Halstead)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42742

CERTIFICATE OF DEATH.

167

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *Morsey Hospital* ST. *17* WARD)

2-FULL NAME *Levi Halstead*

(Residence in Baltimore: No. *760 W Melberry St*, St. *9* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*

4-COLOR OR RACE, *Color*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)

6-DATE OF BIRTH, *April 1*
(Month) (Day) (Year)

7-AGE, *32* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Labourer*
(b) General nature of industry, business, or establishment in which employed (or employer), *040*

9-BIRTHPLACE, (State or Country), *Ta*

PARENTS.

10-NAME OF FATHER, *Sam Halstead*

11-BIRTHPLACE OF FATHER (State or Country), *Ta*

12-MAIDEN NAME OF MOTHER, *Don't know*

13-BIRTHPLACE OF MOTHER (State or Country), *Ta*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Mary Halstead*
(Address) *760 W Melberry*

15-
MAY 1 1920 *Robert P. Harrison,*
Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *April 27, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *(Inquest, autopsy or inquiry.)* thereon and from the evidence obtained by said *(Inquest, autopsy or inquiry.)* find that said deceased came to *his* death on the day stated above.
The CAUSE OF DEATH* was as follows:
Found Burns on his body caused by explosion in boiler
(Duration) yrs. mos. *24 hrs*
CONTRIBUTORY *Accident*
(Secondary)
(Duration) yrs. mos. *none*
(Signed) *R. J. Gorman* M. D.
(Coroner.)
4-28, 1920 (Address) *47 W. Saratoga*
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence
19-PLACE OF BURIAL OR REMOVAL, *W. Auburn St* DATE OF BURIAL, *May 2, 1920*
20-UNDERTAKER, *W. Brown & Son* ADDRESS, *108 W. Montgomer*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42743

D42743

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Judge(a) RESIDENCE. No. 538 S. Milton Ave. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds.How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
66				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cigar-maker

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown9 BIRTHPLACE (city or town)
(State or country)Germany

10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER (city or town)
(State or country)Germany

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Germany14 Informant Hospital Records

(Address)

H.T.H.15 Filled Robert P. Harris

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1920

17

I HEREBY CERTIFY, That I attended deceased from April 26, 1920, to April 30, 1920that I last saw him alive on April 29, 1920and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 2 yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum.(Signed) George R. Wilkison, M. D.4-30-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Evangelical Ch.May 3, 1920

20 UNDERTAKER

ADDRESS

H. Lander Sons1710 Pk.

MAY 1 1920

Burial permit clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42744

CERTIFICATE OF DEATH.

154 D42744
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 Hull ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Edward Wolfgram(Residence in Baltimore: No. 1116 Hull St.; 46 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. married
(Write the word.)6-DATE OF BIRTH, Sept. 15th, 1839
(Month) (Day) (Year)7-AGE, 80 yrs., 7 mos., 14 ds. If LESS than 1 day, 8 hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). 409-BIRTHPLACE, (State or Country), Germany10-NAME OF FATHER, ?11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER ?13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. P. Harrison(Address) 1570 Fort Ave15- Robert P. Harrison,MAY 1 1920 191 Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 - 29, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from 4 - 1 - 1920, to 4 - 29 - 1920, that I saw him alive on 4 - 29 - 1920, and that death occurred, on the date stated above, at 9.30 P. m. The CAUSE OF DEATH* was as follows: oneEdema of lung.
(Duration) 10 yrs., mos., ds.CONTRIBUTORY (Secondary) old age
(Duration) 80 yrs., mos., ds.(Signed) R. P. Harrison M. D.
4-30, 1920 (Address) 1570 Fort Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.Where was disease contracted, if not at place of death? Former or usual residence 19-PLACE OF BURIAL OR REMOVAL, St Pauls Cem. DATE OF BURIAL, May 3, 192020-UNDERTAKER H. Sanders Sons ADDRESS 1741 Park St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE very important. See instructions on back of certificate.

D42745

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42745

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *McHone Retmar* ST.: *28th* WARD)REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Miss Susan Boyce

(a) RESIDENCE. NO.

Formerly 4637- Westminister Phila. Pa

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1* yrs. *1* mos. *0* ds. How long in U. S., if of foreign birth? *Don't know* mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) *June 3rd 1888*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
32 0 10 29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

Cooking -

(c) Name of employer

Don't know

9 BIRTHPLACE (city or town) (State or country)

*Ireland*10 NAME OF FATHER *Patrick Boyce*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*12 MAIDEN NAME OF MOTHER *Grace Muegal*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

*Records of McHone Retmar
McHone Bald. and -**Robert P. Harrison,*

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-30* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

April 1st 19*19*, to *Apr 30* 19*20*,that I last saw him alive on *Apr 29th* 19*20*,and that death occurred, on the date stated above, at *8.20 A.* m.

The CAUSE OF DEATH* was as follows:

*Pulmonary Oedema-Post Chr. Cardiac
Dilatation**abt*(duration) *One* yrs. *—* mos. *—* ds.

CONTRIBUTORY (Secondary)

*Chr. Melancholia -**abt*(duration) *One* yrs. *—* mos. *—* ds.18 Where was disease contracted if not at place of death? *Phila Pa.*Did an operation precede death? *no* Date of _____Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Frank J. Flannery* M. D., 19 (Address) *McHone Sta E. Balto and -*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral Cemetery**May-1/* 19*20*

20 UNDERTAKER

STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

108 W. NORTH AVE.

MAY 1 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42746

D42746

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3607 Chester Place. ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 3607 Chester Place. 26 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) April 19-19197 AGE Years Months Days If LESS than 1 day, hrs. or min. 11 11 — — —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) md.10 NAME OF FATHER George Jaeger.11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) md.12 MAIDEN NAME OF MOTHER May Jaeger.13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) md.14 Informant May Jaeger (Address) 3607 Chester Place.15 Robert P. Harrison, Registrar

MAY 1 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 192017 I HEREBY CERTIFY, That I attended deceased from April 27, 1920, to April 29, 1920, that I last saw h. alive on April 27, 1920, and that death occurred, on the date stated above, at 3.30 A. M. The CAUSE OF DEATH* was as follows:Pneumonia(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. E. McManahan, M. D.Address 3508 Bank St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn Cem.

20 UNDERTAKER

Lilly and Ziehl

ADDRESS

403 S. Wolfe

Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

14 042742

HEALTH DEPARTMENT—CITY OF BALTIMORE

042742

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST.: *7*)

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Erelyn Jones

(a) RESIDENCE. NO.

*1509 Madison St.*WARD. *12th*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

Dec 14-1918

7 AGE

1 Years*4* Months*16* Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Thomas Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Rebecca Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Hospital Record H. H.

MAY 1 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 30 1920

17

I HEREBY CERTIFY, That I attended deceased from

*April 17, 1920, to April 30, 1920.*that I last saw her alive on *April 30, 1920.*and that death occurred, on the date stated above, at *6:40 a.m.*

The CAUSE OF DEATH* was as follows:

General military tuberculosis(duration) yrs. mos. ds. *41*

CONTRIBUTORY (Secondary)

None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

PT's home

Did an operation precede death?

No

Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Autopsy

(Signed)

W. H. Harrison

M. D.

, 19 (Address)

H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laurel

DATE OF BURIAL

May 2 1920

20 UNDERTAKER

John W. Henderson

ADDRESS

1502 E. Monument

D42748

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42748

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1714 E Chase* ST. *8* WARD)2-FULL NAME *A. Margaret Bomhoff*(a) RESIDENCE. NO. *1714 E Chase* ST. *8* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *72* yrs.

mos.

10 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

*White*5 Single, Married, Widowed,
or Divorced (write the word)*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *April 9, 1848*

7 AGE

Years

Months

Days

If LESS than
1 day. hrs.
or min.*72**20*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Housekeeper*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Balti Md*10 NAME OF FATHER: *Henry Bomhoff*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Bermary*12 MAIDEN NAME OF MOTHER *Mary M. Mueller*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Bermary*

14

Informant
(Address)*Mr. Friedrich Meiers
1714 E Chase*

Robert F. Harrison,

Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 29, 1920*

17

I HEREBY CERTIFY, That I attended deceased from
April 25, 1920 to *April 29, 1920*that I last saw him alive on *April 28, 1920*and that death occurred, on the date stated above, at *7:59* m.

The CAUSE OF DEATH* was as follows:

*Cerebral
Stimulus*CONTRIBUTORY
(Secondary)(duration) yrs. *6* mos. ds.(duration) yrs. *4* mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *F. F. Meiers*14/19 Address *1308 N. E. Ave.**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Ingles Park Cemetery**May 1, 1920*

20 UNDERTAKER

ADDRESS

*Henry Horck Sur**1301 E. E. Ave.*

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MAY 1 1920

D42749

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42749

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 174 Munsen Al. ST. 17 WARD)

2-FULL NAME John Miller

(Residence in Baltimore: No. 524 Munsen Alley

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

(Month) (Day) (Year)

7-AGE,

28

yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

md.

10-NAME OF FATHER,

John Miller

11-BIRTHPLACE OF FATHER (State or Country),

md.

12-MAIDEN NAME OF MOTHER,

Jennie Johnson

13-BIRTHPLACE OF MOTHER (State or Country),

md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Miller

(Address)

524 Munsen Alley

15-

Robert P. Harrison,

Filed

1920

191

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 27, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Cerebral shock caused through the head. Homicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Hemorrhage in brain

(Duration) yrs. mos. ds.

(Signed)

J. E. Smith M. D.

4/10

(Coroner)

1920

(Address)

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Charles B. Jones 211 Pine

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHISICIAN'S AND STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 1 1920

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If physician's statement is very important. See instructions on back of certificate.

D42750

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42750

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE (No. *1313 Whateast* ST.: *15* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1313 Whateast* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Calons

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widowed

6-DATE OF BIRTH,

(Month) (Day) (Year)

7-AGE,

68

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

Domestic

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

1920

191

Robert P. Harrison,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr. 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

And that said deceased came to death *inquest* (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary TB
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Signed) *P. B. Smith* M. D. (Coroner) *May 1, 1920* Address *910 Lexington St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

Samuel Cemetery

May 12, 1920

20-UNDERTAKER

ADDRESS

Sam. W. Chase -

1460. Asher st

D42751

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42751

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8¹/₂ + James St. Morris Park 25) WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 8¹/₂ + James St. Morris Park St. 49 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH,

Jan 12th, 1871
(Month) (Day) (Year)

7-AGE,

49 yrs. 3 mos. 17 ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 0379-BIRTHPLACE,
(State or Country),

Balt Md

PARENTS.

10-NAME OF FATHER,

Chas T. Allenbaugh

11-BIRTHPLACE OF FATHER
(State or Country),

Balt Md

12-MAIDEN NAME OF MOTHER

William. Hare

13-BIRTHPLACE OF MOTHER
(State or Country),

Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Harry Hamilton(Address) 8¹/₂ + James St.

15-

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 19 1920, to April 28 1920, that I saw him alive on April 28 1920, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis
Carcinoma of Stomach
(Duration) yrs. 2 mos. 9 ds.CONTRIBUTORY
(Secondary)(Signed) Robt. J. Murray M. D.
May 3, 1920 (Address) 516 N. Fremont St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cemetery

DATE OF BURIAL,

May 2, 1920

20-UNDERTAKER

See Lumbard & Co. Contractors.

N.B.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42752

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42752

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *221 London Ave* St. *20* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *221 London Ave* St. *38* yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

female

4-COLOR OR RACE

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *widow*

6-DATE OF BIRTH

March 12, 1860
(Month) (Day) (Year)

7-AGE

60 yrs. *1* mos. *17* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9-BIRTHPLACE, (State or Country),

Austria

PARENTS.

10-NAME OF FATHER

Gottfried Fritsch

11-BIRTHPLACE OF FATHER (State or Country),

Austria

12-MAIDEN NAME OF MOTHER

Margaret Kellar

13-BIRTHPLACE OF MOTHER (State or Country),

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Geo. Kuehn*(Address) *215 London Ave.*

15-

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 29, 1920
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *April 26, 1920*, to *April 29, 1920*, that I saw her alive on *April 28, 1920*, and that death occurred, on the date stated above, at *9¹⁵* a.m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis
from Strain (Duration) *at 1* yrs. — mos. — ds.CONTRIBUTORY *Cardiac Failure* (Secondary)(Signed) *Robert P. Harrison* M. D.
Apr. 29, 1920 (Address) *1328 P. Charles St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cemetery

DATE OF BURIAL,

May 3, 1920

20-UNDERTAKER

Geo. Lambach Son

ADDRESS

647 N. Radcliff

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION very important. See instructions on back of certificate.

MAY 1 1920

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42753

CERTIFICATE OF DEATH

112753

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *3905 Falls Rd.* ST. *13* WARD)

2-FULL NAME *Mrs. Nora Reilly*

(Residence in Baltimore: No. *3905 Falls Road* *Sinnamary, Pennsylvania*)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and file out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE *Married* MARRIED WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH *Unknown* 1876 (Month) (Day) (Year)

7-AGE *44* yrs. mos. ds. or min. If LESS than 1 day, hrs. min.?

8-OCCUPATION (a) Trade, profession or particular kind of work *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer) *037*

9-BIRTHPLACE (State or country) *Ireland*

10-NAME OF FATHER *John Murphy*

11-BIRTHPLACE OF FATHER (State or country) *Ireland*

12-MAIDEN NAME OF MOTHER *Nora Murphy*

13-BIRTHPLACE OF MOTHER (State or country) *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Her husband Mrs. Reilly*

(Address) *3905 Falls Rd*

15-

Robert P. Harrison.

MAY 1 1920

Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *4/29* 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Feb 1st* 1920, to, *4/29* 1920,

that I saw her alive on *4/29* 1920, and that death occurred, on the date stated above, at *8* m.

The CAUSE OF DEATH* was as follows:

Cancer Stomach

(Duration) *3* yrs. mos. ds.

Contributory (SECONDARY) *Exhaustion*

(Duration) *3* yrs. mos. ds.

(Signed) *Henry J. O'Connell* M. D.

4/29 1920 [Address] *1461 E. 7th St*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Cathedral Cemetery*

DATE OF BURIAL *May 3- 1920*

20-UNDERTAKER *Norace Burgeson*

ADDRESS *363 Falls Road*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42754

D42754

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Fea West End Maternity 19

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Baby Crist

(Residence in Baltimore: No.

1504 W. Lexington

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH.

Apr. 27, 1920

(Month)

(Day)

(Year)

7-AGE,

yrs. mos. 2 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Maryland

PARENTS.

10-NAME OF FATHER,

Dove D. Heintz

11-BIRTHPLACE OF FATHER (State or Country),

? America?

12-MAIDEN NAME OF MOTHER

Margaret Crist

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

per Dr. J. A. Abbott, M.D.

(Address)

15-

MAY 1 1920

Robert P. Harrison,

191

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 29, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr. 27, 1920, to Apr. 29, 1920,

that I saw her alive on Apr. 29, 1920,

and that death occurred, on the date stated above, at 7:45 pm.

The CAUSE OF DEATH* was as follows:

Premature (8 mos)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Lyman J. Abbott, M.D.

Apr. 29, 1920 (Address) Franklin G. Hays

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

Hopkins Hospital

Per. Wm. E. WOODALL

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Important. See instructions on back of certificate.

D42755

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42755

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2234 Linden Ave ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Stern(a) RESIDENCE. NO. 2234 Linden Ave ST. 14 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Lafayette mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Stern6 DATE OF BIRTH (month, day, and year) Nov. 30th 18497 AGE Years 70 Months 5 Days — If LESS than 1 day, hrs. — or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Isaac Gans11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Elija Gurrbach13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant Max Gans (Address) 2234 Linden Ave15 Filed 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30th 192017 I HEREBY CERTIFY, That I attended deceased from Apr 3, 1920, to Apr 30, 1920, that I last saw her alive on Apr 30, 1920, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Labour. Pneumonia(duration) yrs. 10 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. S. Lloyd, M. D., 19 (Address) 2232 Euton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Hebrew BurialMay 1st 1920

20 UNDERTAKER

ADDRESS

Edward Southeim118 N. W. 1st St.

MAY 1 1920

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH CARE. CAUSE OF DEATH should be stated EXACTLY. PHYSICIAN should state statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

D42756

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42756

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes' Hospital* WARD)

2-FULL NAME

Mr. Patrick J. Ryan

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

(Usual place of abode)

1617 Baker St.

WARD.

Length of residence in city or town where death occurred

60 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

60 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1849

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*71 yrs**?**?*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Gardener

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*"**"**"*

12 MAIDEN NAME OF MOTHER

*"**"**"*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*"**"**"*

14

Informant (Address)

Mr. James Coffey 1617 Baker St.

15 Filed

Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 29 1920

17

I HEREBY CERTIFY, That I attended deceased from

*April 27, 1920, to April 29, 1920*that I last saw him alive on *April 27, 1920,*and that death occurred, on the date stated above, at *5:30 P. m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) *1* yrs. *1* mon. *1* ds.

CONTRIBUTORY

(Secondary)

Pulmonary adenoma; acute cardiac dilatation (duration) *1* yrs. *1* mos. *1* ds.

18 Where was disease contracted

If not at place of death? *1617 Baker St.,*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Hester Physical finding*(Signed) *William P. Slagter, M.D.*, 19 (Address) *St. Agnes' Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cathedral**May 3 1920*

20 UNDERTAKER

ADDRESS

Martin Fahy & Sons 1827 W. North

MAY 1 1920

Burial Permit Clerk.

N. B.—WRITING SHOULD BE EXACTLY AS STATED. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D42757

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42757

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital WARD)

2-FULL NAME

Mr. G. H. Smith

(a) RESIDENCE. NO.

(Usual place of abode)

Mr. J. J. Thomas ST.

WARD.

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

M.5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofGreece Smith

6 DATE OF BIRTH (month, day, and year)

Jan 15 1884

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.36329

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Machinist

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Md.

10 NAME OF FATHER

George H. Smith

11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER

Charles M. H. H. H.

13 BIRTHPLACE OF MOTHER (city or town)

Md.

(State or country)

14

Informant
(Address)Mr. G. H. Smith
Mr. J. J. Thomas

15

Filed

, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Apr 20 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr 27, 1920, to Apr 30, 1920.that I last saw him alive on Apr 30, 1920.and that death occurred, on the date stated above, at 1045 A.M.

The CAUSE OF DEATH* was as follows:

Rt massive pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Pulmonary edema

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Mr. ThomasDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? History of physical(Signed) Dr. J. J. Thomas, 19 (Address) St. Agnes' Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cashbury M. Co. Cemetery

DATE OF BURIAL

May 3 1920

20 UNDERTAKER

Resurrection

ADDRESS

ResurrectionJ. F. Elms

N. B.—WRITE EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42758

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42758

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Off Davison's Chemical Co.

REGISTERED No. C

CITY OF BALTIMORE (No.

Curtis Bay.

St.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Thomas Jones. (C)

(Residence in Baltimore: No.

1116 Woodyear St.

St.; yrs., 30 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male.

4-COLOR OR RACE,

Colored.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH,

February 18th. 1920.

(Month)

(Day)

(Year)

7-AGE,

58

1

2

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

Seaman. 074

9-BIRTHPLACE,

(State or Country),

Lancaster Co. Va.

10-NAME OF FATHER,

Joseph Jones. (C)

11-BIRTHPLACE OF FATHER

(State or Country),

Lancaster Co. Va.

12-MAIDEN NAME OF MOTHER

Sarah. --- (C)

13-BIRTHPLACE OF MOTHER

(State or Country),

Lancaster Co. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cora Jones. (C) wife.

(Address) 1116 Woodyear St.

15-

Robert P. Harrison,

Filed.

MAY 1 1920

191

Registrar.

Barclay Peritt Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Missing March 20, 1920.
Body found April 29th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, au-
topsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

(Duration).... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signature)

(Duration).... yrs. mos. ds.

(Signature) M. D.

Apl. 30, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death.... yrs. mos. ds. State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

mt Auburn

May 2, 1920

20-UNDERTAKER

ADDRESS

Edward Ringgold 4632 Bay

D42759

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42759

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *329 Ellamont Ave* ST.: *70* WARD)

2-FULL NAME

Mattie Ryan

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. *329 Ellamont Ave* ST. *70* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *B* 5 Single, Married, Widowed, or Divorced (write the word) *Child*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec 14 1913*7 AGE Years *6* Months *4* Days *15* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*(b) General nature of industry, business, or establishment in which employed (or employer) *None*(c) Name of employer *None*9 BIRTHPLACE (city or town) (State or country) *Balto*10 NAME OF FATHER *Wm Ryan*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Queen Anne's*12 MAIDEN NAME OF MOTHER *Agnes*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Anne Arundel*

14

Informant (Address) *Wm Ryan*Filed *MAY 1 1920* Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4-29 1920*

17

I HEREBY CERTIFY, That I attended deceased from *April 28 1920* to *April 30 1920*, that I last saw her alive on *April 24 1920*and that death occurred, on the date stated above, at *2 a* m.

The CAUSE OF DEATH* was as follows:

*Exhaustion*CONTRIBUTORY (Secondary) *Exhaustion* (duration) yrs. mos. *7* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Wm Ryan* M. D. (Address) *400 N Payson St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Edward W. Ryan *403 E. Bond and Catons*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D42760

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42760

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs. Frances Smith

(a) RESIDENCE. NO.

1215 Hartford

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

3 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

3 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) ~~WIFE~~Mrs. Herbert Smith

6 DATE OF BIRTH (month, day, and year)

about 29

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Austria

10 NAME OF FATHER

Don't know11 BIRTHPLACE OF FATHER (city or town)
(State or country)Austria

12 MAIDEN NAME OF MOTHER

Don't know13 BIRTHPLACE OF MOTHER (city or town)
(State or country)"

14

Informant
(Address)Herbert C. Smith1215 Hartford Ave.

15

Filed

1920Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 - 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 19, 1920, to April 30, 1920.that I last saw her alive on April 30, 1920.and that death occurred, on the date stated above, at 3:15 p. m.

The CAUSE OF DEATH* was as follows:

Hyperemesis Gravidum

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? yes Date of 4/28/20Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lyman S. Abbott, M. D., 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

DATE OF BURIAL

May 3 1920

20 UNDERTAKER

William Cook

ADDRESS

502 E. NorthAve

N. B. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D42761

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42761

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *523 W Bame*ST.: *22*

WARD)

REGISTERED NO. C

2-FULL NAME

Berby Wilkantis

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *523 W Bame St*

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male* 4-COLOR OR RACE, *white* 5-SINGLE, *single*, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH, *5* *1* *1920*
(Month) (Day) (Year)

7-AGE, yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *none*
(b) General nature of industry, business, or establishment in which employed (or employer). *000*

9-BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER, *John Wilkantis*

11-BIRTHPLACE OF FATHER (State or Country), *Russia*

12-MAIDEN NAME OF MOTHER *Maud Guskonis*

13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Wilkantis*(Address) *523 W Bame St*15- *MAY 1 1920* Robert P. Harrison,

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *5* *1* *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 1 1920*, to *May 1 1920* that I saw him alive on *May 1 1920*, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Effusion of head
neurovascular instrument
delivery (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Inhalation* (Duration) yrs. mos. ds.

(Signed) *Rep. Orlan* M. D. *May 1 1920* (Address) *654 Columbia*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer*DATE OF BURIAL, *May 1 1920*20-UNDERTAKER, *John Griebauckas*ADDRESS *425 S. Paca St.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of OCCUPATION is very important. See instructions on back of certificate.

D42762

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42762

1-PLACE OF DEATH

CITY OF BALTIMORE: No. *1103 Columbia Ave* ST.: *21* WARD)

2-FULL NAME

Theresa M. Findling

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE

No. *1103 Columbia Ave* ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *63* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *John W. Findling*

6 DATE OF BIRTH (month, day, and year) *Oct. 8 1857*

7 AGE Years *63* Months *6* Days *27* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md

10 NAME OF FATHER

John Zipprian

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

*Theresa M. Findling
1103 Columbia Ave*

15

Filed *1920**Robert P. Harrison*

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 30 1920*

17

I HEREBY CERTIFY, That I attended deceased from *April 26*, 1920, to *April 30*, 1920, that I last saw her alive on *April 30*, 1920, and that death occurred, on the date stated above, at *9 a* m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*Home*Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *William C. Lee* M. D.*April 30* (Address) *535 Lytle St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park Cemetery**May 3 1920*

20 UNDERTAKER

ADDRESS

*James F. Dignan**1000 S. Park*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 12763

D42763

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 N. Hamburg ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 719 N. Hamburg St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, *Married*
WIDOWED, OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

Aug. 29, 1871
(Month) (Day) (Year)

7-AGE

49

8

mos.

1

ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, business,
or establishment in which
employed (or employer)

Salonkeeper

9-BIRTHPLACE,
(State or Country),

ind.

10-NAME OF
FATHER,

John Pfeiffer

11-BIRTHPLACE
OF FATHER
(State or Country),

Germany

12-MAIDEN NAME
OF MOTHER

Lottie Rich

13-BIRTHPLACE
OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Florence Pfeiffer

(Address)

719 N. Hamburg St.

15-

Robert P. Harrison,

MAY 1 1920

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Apr 30, 1920
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from
Feb. 8, 1920, to Apr. 30, 1920,

that I saw him alive on Apr. 29, 1920,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. 1 mos. ds.

(Signed) Hubert S. Bloch M. D.

Apr 30, 1920, (Address) 1014 N. La Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Catholic Cemetery

Apr 4, 1920

20-UNDERTAKER

ADDRESS

James F. Dignan

1000 S. Paca St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42764

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2444 Fleet

ST.:

WARD)

2-FULL NAME

J. Stanislaw Szymanski

(a) RESIDENCE. NO.

2444 Fleet

ST.:

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

7 yrs. 2 mos. 1 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

2/29/1916

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

4

2

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

Joseph Szymanski

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russian Poland

12 MAIDEN NAME OF MOTHER

Jenna Kuchan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Austria

14

Informant
(Address)Jacob Szymanski
2444 Fleet

15

Filed

Bureau Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-1

1920

17

I HEREBY CERTIFY, That I attended deceased from

4-29, 1920, to 4-30, 1920.

that I last saw him alive on 4-30, 1920.

and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Measles, Broncho Pneumonia
& Bacterial Otitis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Catheter & Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Signs & symptoms

(Signed) H. A. Schubert, M. D.

5-1, 1920 (Address) 1623 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary

5/1

1920

20 UNDERTAKER

ADDRESS

William Fialkowski 1618 Eastern

MAY 1 1920

Robert P. Harrison,

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE of DEATH is very important. See instructions on back of certificates.

Physicians should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. ST.* 7 WARD)

2-FULL NAME

Frederick Williams

(a) RESIDENCE. NO.

Johns Hopkins Hosp.

WARD. *Edlitt City Md*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1* yrs. *1* mos. *17* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Caucasian* 5 Single, Married, Widowed, or Divorced (write the word) *Child*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year) *Sept 2 1918*

7 AGE Years *1* Months *6* Days *1* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md* (State or country)

10 NAME OF FATHER *Barnett Williams*

11 BIRTHPLACE OF FATHER (city or town) *Unknown* (State or country)

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) *Unknown* (State or country)

14 Informant *Hospital Record* (Address) *7. 26. 26*

15 *MAY 2 - 1920* *ROBERT B. KRAUTER* Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 30 1920*

17

I HEREBY CERTIFY, That I attended deceased from *March 18, 1920, to April 30, 1920.* that I last saw him alive on *April 30, 1920.* and that death occurred, on the date stated above, at *10:00 a.m.*

The CAUSE OF DEATH* was as follows:

Disseminated Tuberculosis (Glands, bones, lungs,

(duration) yrs. *4* mos. *3* ds.

CONTRIBUTORY (Secondary)

None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Unknown*

Did an operation precede death? *No* Date of

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Autopsy*

(Signed) *Harold H. Higgins, M. D.*

5/1, 1920 (Address) *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cemetery at Pimlico Road Co. Maryland.

20 UNDERTAKER

Scott M. Starr

ADDRESS

Edlitt City

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42766

CERTIFICATE OF DEATH.

D42766

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Prot. Infirmary* ST.; *W* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Union Prot. Infirmary* St.; yrs. mos. *27* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH

July

(Month)

19

(Day)

1858

(Year)

7-AGE

*61**9**17*

ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Manufacturer
045

9-BIRTHPLACE, (State or Country)

Ill.

PARENTS.

10-NAME OF FATHER

Charles Ridgely

11-BIRTHPLACE OF FATHER (State or Country)

Ill.

12-MAIDEN NAME OF MOTHER

June Barrett

13-BIRTHPLACE OF MOTHER (State or Country)

Ill.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Kate D. Ridgely*(Address) *1908 Q St. N.W. Wash. D.C.*

15-

MAY 2 - 1920

Filed

191

ROBERT F. CHAUTEE

Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

April

(Month)

30

(Day)

1920

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 5th 1920, to *April 30th 1920*that I saw him alive on *April 30th 1920*and that death occurred, on the date stated above, at *11⁵⁹ p.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism(Duration) *1* yrs. *1* mos. *1* ds.CONTRIBUTORY (Secondary) *Pulmonary Embolism*(Duration) *1* yrs. *1* mos. *1* ds.(Signed) *J. N. Cunningham* M. D.*April 30, 1920* (Address) *U. P. I.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Springfield Ill.*

19-PLACE OF BURIAL OR REMOVAL

Springfield Ill.

DATE OF BURIAL

May 1, 1920

20-UNDERTAKER

John Mitchell 1201 N. Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42762

CERTIFICATE OF DEATH.

79 D42762

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1443 Battery Ave. WARD)

2-FULL NAME

(Residence in Baltimore: No. 1443 Battery Ave. St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widow6-DATE OF BIRTH, Nov 9, 1843
(Month) (Day) (Year)7-AGE, 76 yrs. 6 mos. 21 ds. If LESS than 1 day,hrs. ormin.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Iron Moulder
(b) General nature of industry, business, or establishment in which employed (or employer). has not work for yrs.9-BIRTHPLACE, (State or Country), Balto Md10-NAME OF FATHER, A. S. Hyson11-BIRTHPLACE OF FATHER (State or Country), Unknown12-MAIDEN NAME OF MOTHER, Dewry13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Hyson(Address) 1443 Battery Ave.

15-

MAY 2 - 1920

ROBERT E. KRAUTER

BALTIMORE REGISTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 30, 1920
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from April 15 1920, to April 30 1920, that I saw him alive on April 30 1920, and that death occurred, on the date stated above, at 7:15 p.m.

The CAUSE OF DEATH* was as follows:

Coronary Artery Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Glomerulonephritis

(Duration) yrs. mos. ds.

(Signed) Robert E. Krauter M. D.5-6-20 (Address) 1443 Battery Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto CemeteryDATE OF BURIAL, May 3, 192020-UNDERTAKER, E. J. FanningADDRESS 1458 Battery Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42768

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42768

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 772 W Saratoga ST.; H WARD)

2-FULL NAME

(a) RESIDENCE. NO. 772 W. Saratoga ST., H WARD.(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/7/177 AGE Years 2 Months 11 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Monistown (State or country) N.J.10 NAME OF FATHER Jessie Hall11 BIRTHPLACE OF FATHER (city or town) A.A. County (State or country) MD12 MAIDEN NAME OF MOTHER Mary Johnson13 BIRTHPLACE OF MOTHER (city or town) Wt. Calvary (State or country) MD14 Informant Jessie Hall (Address) 772 W. Saratoga St.15 MAY 2 - 1920 ROBERT R. IRVING Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30/ 19 2017 I HEREBY CERTIFY, That I attended deceased from 4/25/ 19 20, to 4/30/ 19 20, that I last saw her alive on 4/29/ 19 20, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Wetlock & Powell E. M. D.19 PLACE OF BURIAL, CREMATION OR REMOVAL Magdalen Rd. DATE OF BURIAL May 2 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Magdalen Rd. DATE OF BURIAL May 2 192020 UNDERTAKER Wm. G. G. Locks ADDRESS 1302

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42769

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

138 D42769

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 856 Raborg

2-FULL NAME

Kitty West

(Residence in Baltimore: No.

856 Raborg

ST: 18 WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

May 28, 1905 (Month) (Day) (Year)

7-AGE,

15 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife 070

9-BIRTHPLACE, (State or Country),

md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

John West
Don't know
Jane West
Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Marie Lee
856 Raborg

15-

Filed MAY 2 1920

ROBERT E. KRAUTER
Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 30, 1920 (Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Purpural Eclampsia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. X. Gorman M. D. (Coroner.)

5-1-1920 (Address) 117 W. Parake

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Luke's

May 3, 1920

20-UNDERTAKER

ADDRESS

David Easton

916

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42770

CERTIFICATE OF DEATH.

D42770

PLACE OF DEATH

CITY OF BALTIMORE (No. 1121 McCulloh St. 11

2-FULL NAME William B. Boyd

(Residence in Baltimore: No. 1121 McCulloh

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

June 10, 1871

(Month) (Day) (Year)

7-AGE,

48

10 mos. 20 ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... Labour
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER,

Wm. B. Boyd

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER

Sarah Gassaway

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Boyd

(Address) 1121 McCulloh St.

15-

MAY 2 - 1920

ROBERT E. LAUTER

Filed

REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 30, 1920

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. Edw. Smith

(Coroner) M. D.

1911 (Address) 710 E. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Wt. Auburn Cem

DATE OF BURIAL,

May 3, 1920

20-UNDERTAKER

Samuel E. Harris

ADDRESS

916

D42771

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42771

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1050 Ralorg ST.: 18 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 1050 Ralorg ST. Life WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

colored

5 Single, Married, Widowed, or Divorced (write the word)

single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 11, 1918

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

2319

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

MAIL
000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore

10 NAME OF FATHER

Thomas Brown11 BIRTHPLACE OF FATHER (city or town)
(State or country)Baltimore

12 MAIDEN NAME OF MOTHER

Martha Collins13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Baltimore

14

Informant

Martha Collins Brown
May 21, 1920

15

Filed

19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 1 1920

17

I HEREBY CERTIFY, That I attended deceased from
April 28, 1920, to April 30, 1920,
that I last saw him alive on April 30, 1920,
and that death occurred, on the date stated above, at 6:15 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial)(duration) yrs. mos. ds. 3CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?unknownDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

auscultation chest

(Signed)

J. W. V. Clift M. D.
May 1, 1920 (Address) Robt Garrett Hosp Disp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

My Auburn Bur May 3 1920

20 UNDERTAKER

ADDRESS

David Euston 916

PHYSICIANS should state EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42772

CERTIFICATE OF DEATH.

D42772

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 791 N Mulberry ST.; 4 WARD)2-FULL NAME Charles Kennedy(Residence in Baltimore: No. 791 N Mulberry St.; 21 yrs., 7 mos., 16 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male4-COLOR OR RACE. Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)6-DATE OF BIRTH, July 18, 1898

(Month)

(Day)

(Year)

7-AGE, 21 yrs., 7 mos., 16 ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). 0409-BIRTHPLACE, (State or Country), Maryland10-NAME OF FATHER, Zachariah Kennedy11-BIRTHPLACE OF FATHER (State or Country), Maryland12-MAIDEN NAME OF MOTHER Emma Durnett13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Shirley Durnett(Address) 791 N Mulberry St

15-

MAY 2 - 1920

ROBERT A. KRAUTER

Filed....., 191.....

BALTIMORE HEALTH DEPARTMENT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 29, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 23, 1920, to Apr 29, 1920, that I saw him alive on Apr 29, 1920, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....Aspirin
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) William E. Burton M. D.Apr 30, 1920 (Address) 762 Josephine

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, W. Auburn AveDATE OF BURIAL, May 3, 192020-UNDERTAKER, Daniel E. EganADDRESS, 916 Penna

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D42773

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

115 D42773
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 E. 30th ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Franklin G. Davis

(a) RESIDENCE

No. 923 E. 30th

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yr.

mos.

ds.

How long in U. S., if of foreign birth?

yr.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Married Davis

6 DATE OF BIRTH (month, day, and year)

May 12 1871

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

40

11

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Wilson & Higgins

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Sam Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Married Davis
923 E. 30th St.

15

MAY 2 - 1920

ROBERT E. KRAUTH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 27 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 27, 1920, to May 1, 1920.

that I last saw him alive on Apr 30, 1920.

and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Ac. Hepatitis

(duration) 12 yrs. 12 mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Dalton M. D.

19 (Address) 1353 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Providence

May 7 1920

20 UNDERTAKER

ADDRESS

Wm. C. ...

1353 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42774

CERTIFICATE OF DEATH.

D42774

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3222 Greenmount Ave ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Hickman

(a) RESIDENCE. NO. 3222 Greenmount Ave ST., 12 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. 28 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced
HUSBAND of John T. Hickman
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 5 1894

7 AGE 25 Years 7 Months 26 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country) Howard County

10 NAME OF FATHER John S. De. Ories

11 BIRTHPLACE OF FATHER (city or town) Born on way
(State or country) from Holland - to U. S. A.

12 MAIDEN NAME OF MOTHER Sarah A. King

13 BIRTHPLACE OF MOTHER (city or town) Holland
(State or country)

14 Informant S. A. King
(Address) 3222 Greenmount Ave

15 Filed MAY 2 - 1920 ROBERT A. KELLEY
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Apr. 14, 1920, to May 1, 1920, that I last saw her alive on Apr. 30, 1920, and that death occurred, on the date stated above, at 3.2 - m. The CAUSE OF DEATH* was as follows:

Paralysis "Hemiplegia"

(duration) yrs. mos. ds.

CONTRIBUTORY Cerebral "Cerebral"
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —
if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. G. Prentiss, M. D.

, 19 (Address) 634 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Paran. Harrisonville

May 4 1920

20 UNDERTAKER

ADDRESS

William Cook

503 E. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42775

CERTIFICATE OF DEATH.

79 D42775

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2879 Woodbrook Co. ST. 13 WARD)

2-FULL NAME

John J. Schaffer

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 2879 Woodbrook Co. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? Native mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Wht. 5 Single, Married, Widowed, or Divorced (write the word) Widower5a If married, widowed, or divorced HUSBAND of Emily J. Schaffer (or) WIFE of6 DATE OF BIRTH (month, day, and year) Feb. 10/18427 AGE Years 78 Months one Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ret. Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Manchester (State or country) Pa.10 NAME OF FATHER John Schaffer11 BIRTHPLACE OF FATHER (city or town) Pa. (State or country)12 MAIDEN NAME OF MOTHER Ann Ingles13 BIRTHPLACE OF MOTHER (city or town) Pa. (State or country)14 Informant Mr. Geo. Smith (Address) 2879 Woodbrook Co.15 MAY 2 - 1920 ROBERT F. LAUTER Registrar Serial Permit 0127

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 192017 I HEREBY CERTIFY, That I attended deceased from Apr. 8, 1920, to May 1st, 1920, that I last saw him alive on Apr. 30, 1920, and that death occurred, on the date stated above, at 1:50 m.

The CAUSE OF DEATH* was as follows:

Valvular Ds. of Heart & dilatationCONTRIBUTORY Pulmonary Embolism (Secondary) (duration) Long time yrs. mos. ds. 3 weeks yrs. mos. ds.18 Where was disease contracted No if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? By Autopsy(Signed) Ed Smith M. D. 5/14/20 (Address) 1605 N. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baust. Carroll Co May 8 - 1920

20 UNDERTAKER

William Cook

ADDRESS

5022 North

N. B.—WRITE PLAINLY, WITH ONE ADDRESS ONLY. THIS IS A STATE PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D42776

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bieder Wellman Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 12 WARD)

2-FULL NAME

Marriott Morris Smith

(a) RESIDENCE. No.

2206 N. Calvert

ST.

WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

26 yrs. 2 mos. 14

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

single

6 DATE OF BIRTH (month, day, and year)

April 16, 1894

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

26

2

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Receiving Clerk

(b) General nature of industry, business, or establishment in which employed (or employee)

Hochell & Co. Inc.

(c) Name of employer

Hochell & Co. Inc.

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Barroll Lee Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Margaret Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant

Miss Marriott Morris

(Address)

2206 N. Calvert St

15

Filed

MAY 2 1920

ROBERT B. LEE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 30 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 29th, 1920, to April 30th, 1920,that I last saw him alive on April 29th, 1920,

and that death occurred, on the date stated above, at 9:30 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Physical Examination

(Signed)

H. H. Bieder, M. D.

, 19 (Address)

2724 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Green Mount

May 3 1920

20 UNDERTAKER

ADDRESS

John O'Mitchell 1201 N. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 E. 41st. ST.: 9 WARD)

2-FULL NAME Thomas H. Hamilton

(a) RESIDENCE. No. 621 E. 41st. ST.: WARD. (If nonresident give city or town and State)

(Usual place of abode) Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7, 1842

7 AGE 77 Years 10 Months 22 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Richard Hamilton

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline V. Vernon

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant James P. Hamilton (Address) 1901 W. Baltimore Street

15 MAY 2 - 1920 ROBERT B. TRAUTMAN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29, 1920

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1915, to April 29, 1920, that I last saw him alive on April 29, 1920, and that death occurred, on the date stated above, at 5 P. M. The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

5-1, 1920 (Address) 120 1/2 Paiswick St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

5/3 19 20

20 UNDERTAKER

Henry W. Mears & Son 805 N. Calvert St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATE OF DEATH SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE CAREFULLY SUPPLIED. CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF CAUSE OF DEATH IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42778

D42778

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *102 E Wylie Ave* St.: *27* WARD)

2-FULL NAME

(Residence in Baltimore: No. *102 E Wylie Ave* St.; yrs., *34* mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Feb.

3

1862

(Month)

(Day)

(Year)

7-AGE

58

2

27

ds.

If LESS than 1 day,

....hrs. ormin.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Labor Helper

Baillit Hayward

9-BIRTHPLACE,

(State or Country).

Ind

10-NAME OF FATHER,

Los

E. Compton

11-BIRTHPLACE OF FATHER

(State or Country).

Ind

12-MAIDEN NAME OF MOTHER

Joanna Hurley

13-BIRTHPLACE OF MOTHER

(State or Country).

Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Gay S. Le Compton

624 N. Calverton

15-

MAY 2 - 1920

ROBERT E. LEUTER

Filed

101

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

April 30

1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) And that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *John J. McManus* M. D.

May 2 1920 (Address) *3532 Roland*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

OF BURIAL

Woodlawn Cemetery

Plot 3

20-UNDERTAKER

ADDRESS

A. S. Marshall 3539 Fall Rd

Spec.—6-9-19—H. P. Co.—1000 Bks.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42779

CERTIFICATE OF DEATH.

37

D42779

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital

ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Waters

(a) RESIDENCE. No. 1320 Orleans St.

ST.: _____ WARD. _____

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. _____ mos. _____

ds. _____ How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE

Years

Months

Days

If LESS than 1 day, _____ hrs. or _____ min.

50

Unknown

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

Maryland

(State or country)

12 MAIDEN NAME OF MOTHER

Catherine Ross

13 BIRTHPLACE OF MOTHER (city or town)

Maryland

(State or country)

14

Informant Hospital Records

(Address)

New City Hospital

15

MAY 2 - 1920

ROBERT B. KRAUSE Registrar

Serial Permit 0107

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 29, 1920, to April 30, 1920,

that I last saw her alive on April 29, 1920,

and that death occurred, on the date stated above, at 2:40 A. m.

The CAUSE OF DEATH* was as follows:

Edema of Glottis

(Terminal)

(duration) yrs. _____ mos. _____ ds. _____

CONTRIBUTORY

(Secondary)

Renal artery

(duration) yrs. _____ mos. _____ ds. _____

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

J. H. Pessel

M. D.

Apr 30 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Richmond, Va. May 3-20

20 UNDERTAKER

ADDRESS

Chris. H. Johnson

D42780

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42780

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

Monmouth St.

13 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Thomas J. Copeland

(Residence in Baltimore: No.

816 W. North Ave

St.: 10 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

M.

4-COLOR OR RACE,

W.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH,

April 2nd, 1863

7-AGE,

57 - 9

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).Mfg. Dept.
Cotton Ware9-BIRTHPLACE,
(State or Country).

Rich Square, N.C.

10-NAME OF
FATHER,

Wm. J. Copeland

11-BIRTHPLACE
OF FATHER
(State or Country).

N.C.

12-MAIDEN NAME
OF MOTHER

Rachel Lane

13-BIRTHPLACE
OF MOTHER
(State or Country).

N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

T. J. Copeland

(Address)

816 W. North Ave

15-

Filed

MAY 2 - 1920

ROBERT E. KRAUTER

SPECIAL FIELD REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 30, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from
April 26, 1920, to April 30, 1920,
that I saw him alive on April 30, 1920,
and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration).....yrs.....mos.....da.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....da.

(Signed).....

Charles H. Gray M. D.

4-30, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-
SIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Wood Ridge May 2 - 1920

20-UNDERTAKER

ADDRESS

L. J. G. 1723 Lafayette Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42782

HEALTH DEPARTMENT—CITY OF BALTIMORE

091-061

D42782

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME

(Residence in Baltimore: No.

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <i>Married</i> (Write the word)
6 DATE OF BIRTH <i>July 24, 1873</i> (Month) (Day) (Year)		
7 AGE <i>46 yrs. 8 mos. 6 ds.</i>		If LESS than 1 day, hrs. or min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment which employed (or employer) <i>Secretary Continental Trust Co.</i>		
9 BIRTHPLACE (State or country) <i>Baltimore Md.</i>		
PARENTS	10 NAME OF FATHER <i>William F. Beasley</i>	
	11 BIRTHPLACE OF FATHER (State or country) <i>North Carolina</i>	
	12 MAIDEN NAME OF MOTHER <i>Mary Hewitt</i>	
	13 BIRTHPLACE OF MOTHER (State or country) <i>Kentucky</i>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 MAY 2 - 1920 ROBERT B. LEAUTEA

Filed 191 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 30th, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Apr. 12, 1920, to Apr. 30, 1920.

that I saw him alive on *Apr. 30, 1920.*

and that death occurred, on the date stated above, at *2 P.m.*

The CAUSE OF DEATH* was as follows:

*Broncho-pneumonia
Meningitis (cero-spinal)
(Pneumococcus type 1)*

(Duration) *0 yrs. 0 mos. 19 ds.*

Contributory (SECONDARY)

Meningitis, cerebro-spinal

(Duration) *0 yrs. 0 mos. 3 ds.*

(Signed)

S. L. Dodds M. D.

May 1, 1920 (Address) 3101 Clifton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Johns Cem (Harely)

May 3, 1920

20 UNDERTAKER

ADDRESS

Joseph B. Cook

1003 N. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42783

CERTIFICATE OF DEATH.

D42783

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *St. Paul Apartments* ST.: *11* WARD)

2-FULL NAME

Sallie Cator Hopper

(a) RESIDENCE. NO.

St. Paul Apartments ST.: *11* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *60* yrs. *9* mos. *14* ds. How long in U. S., if of foreign birth? *60* yrs. *9* mos. *14* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(Resident)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Samuel W. T. Hopper

6 DATE OF BIRTH (month, day, and year)

July - 16 - 1859

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

60

9

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town)
(State or country)

Baltimore
Maryland

10 NAME OF FATHER

Robinson M. Cator

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Dorchester Co.
Maryland

12 MAIDEN NAME OF MOTHER

Mary C. H. Pattison

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Dorchester Co.
Maryland

14

Informant
(Address)

Mr. Stuart Cator Hopper (Son)
St. Paul Apts.

15

MAY 2 - 1920

ROBERT A. LEAUTE

Registrar

Barial Permit 0107

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *April 30 1920*

17 I HEREBY CERTIFY, that I attended deceased from *April 19 1920* to *April 30 1920*

that I last saw her alive on *April 30 1920*

and that death occurred, on the date stated above, at *4-30 P. M.*

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos. *12* ds.

CONTRIBUTORY *Double Confluent Ecthyma*

(Secondary) *Phellmonia* (duration) yrs. mos. *12* ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *M. J. H. Porter* M. D.

7/1 1920 Address *422 Rutland Dr.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Green Mount Cemetery

20 UNDERTAKER

STEWART & MOWEN COMPANY

(WILLIAM F. WOODEN, Successor)

DATE OF BURIAL

May 1920

ADDRESS

108 W. NORTH AVE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42784

CERTIFICATE OF DEATH.

D42784

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Rail Road Ave, Mt. Washington

ST. 27 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Charles M. Freeland

(Residence in Baltimore: No.

Rail Road Ave

St. 30 yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

Feb 18, 1888
(Month) (Day) (Year)

7-AGE,

32 yrs. 2 mos. 12 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

Palmer 040

9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF
FATHER,

Wm Freeland

11-BIRTHPLACE
OF FATHER

(State or Country),

Md

12-MAIDEN NAME
OF MOTHER

Minnie Stuber

13-BIRTHPLACE
OF MOTHER

(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm Freeland

(Address)

Mt Washington

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 30, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
April 20 1920, to April 30 1920
that I saw him alive on April 30 1920,

and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Pulmonary and
Intestinal Tuberculosis

(Duration)..... yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)Exposure in the Army
in France

(Duration)..... yrs. mos. ds.

(Signed).....

S. P. W. M. D.

May 1, 1920 (Address)..... 865 N 36th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

Freeland Md

DATE OF BURIAL,

May 3, 1920

20-UNDERTAKER

Ed Roy Stippler

ADDRESS

1258 North

MAY 2 - 1920
Filed

101

ROBERT B. KRAUTER

Social Permit Registrar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D42785

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D42785

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3325 E: Baltimore St ST.: 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

James M: Boston

(a) RESIDENCE. No. 3325 E: Baltimore St ST.: 20 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 8 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of Susie E: Boston (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15th 1852

7 AGE Years 67 Months 8 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machine operator

(b) General nature of industry, business, or establishment in which employed (or employer) Amer Can Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER Saml A: Boston

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Annie Aaron

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs Hettie V: Connor (Address) 3325 E: Balto St

15 MAY 2 - 1920

ROBERT A KRAUTER
Registrar
DEPT OF HEALTH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30 1920

17 I HEREBY CERTIFY, That I attended deceased from 4/20 1920, to 4/30 1920, that I last saw him alive on 4/30 1920, and that death occurred, on the date stated above, at 11 A m. The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physician (Signed) J. J. Brown M. D.

4/20 1920 Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

John Greenmount May 3 1920
20 UNDERTAKER John Greenmount ADDRESS 2008 E. Enoch

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42786

CERTIFICATE OF DEATH.

REGISTERED NO.

D42786

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4138 Roland Ave. ST.: 13 WARD)

2-FULL NAME

Mary R. Miller

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

4138 Roland Ave. ST.: 13 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

47 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of

Benj. H. Miller

6 DATE OF BIRTH (month, day, and year)

June 1-1835

7 AGE

84 Years

10 Months

29 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Aberdeen Maryland

10 NAME OF FATHER

Thomas J. Numbers

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Miss Margaret Miller 4138 Roland Ave.

15 MAY 2 - 1920

ROBERT H. KAUFER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 30 1920

17

I HEREBY CERTIFY, That I attended deceased from March 1 1920 to April 30 1920 that I last saw her alive on April 30 1920 and that death occurred, on the date stated above, at 8:45 A.M. The CAUSE OF DEATH* was as follows:

Pulmonary Embolism
Cardiac insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocardial infarction (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at home only

Did an operation precede death?

No Date of no

Was there an autopsy?

no

What test confirmed diagnosis?

Post mortem examination

(Signed) Vernon J. Kelley M. D.

Address) 3705 Fair Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Perryman (Harford Co.) Md May 3 1920

20 UNDERTAKER

ADDRESS

Horace Burge 363 Talbot St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42787 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

109- D42787
REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 721-Furrow St. 70
2-FULL NAME Lambert Tenfel
(Residence in Baltimore: No. 221 Furrow St. 2 yrs. — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6-DATE OF BIRTH Oct. 3th, 1843 (Month) (Day) (Year)

7-AGE 76 6 25 If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Cabinet Maker (b) General nature of industry, business, or establishment in which employed (or employer) 014

9-BIRTHPLACE (State, or country) Germany.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Tenfel 4.B.
(Address) 214 Furrow St.

15 MAY 3 - 1920 ROBERT B. KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH April 29, 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 29-5 P.M. 1920, to Apr. 29th 1920, that I saw him alive on Apr. 29, 1920, and that death occurred, on the date stated above, at 11.45 P.M. The CAUSE OF DEATH* was as follows:

Strangulated Hernia

Contributory (SECONDARY) Acute diffuse peritonitis (Duration) yrs. mos. 1 day

(Signed) Nathan B. Borden M. D. Apr. 30, 1920. (Address) 214 Wilkes Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Western Cem DATE OF BURIAL May 3, 1920

20-UNDERTAKER ADDRESS Mrs. John W. Tenfel Son 801 W. Fayette

✓
01042788

CERTIFICATE OF DEATH.

REGISTERED No. C.....

21

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1140 St. Hamburg)

MEDICAL CERTIFICATE OF DEATH.

5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Mar., *5th*, *1915*
.....,
(Month) (Day) (Year)

**If LESS than 1 day,
....hrs. or.....min.?**

None good

Baltimore Md.

10-NAME OF FATHER, Charles W. Langohr

11-BIRTHPLACE
OF FATHER
(State or Country), Chicago Ill.

12-MAIDEN NAME
OF MOTHER Marie A. Melk.

13-BIRTHPLACE
OF MOTHER
(State or Country), Baltimore Md

(Informant) Charles M. Lungow

(Address) 1019 Briscoe

MAY 3 - 1920 ROBERT E. KRAUTER

Filed....., 191... **Bureau of Internal Revenue**
Register.

16-DATE OF DEATH, May 1, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1920, to May 1st 1920
that I saw her alive on April 30 1920
and that death occurred, on the date stated above, at 29. m.
The CAUSE OF DEATH* was as follows:

(Duration).....yrs.....mos.....da

CONTRIBUTORY *Valvular Disease of Heart*
(Secondary)

(Duration).....yrs...4...mos.....ds.

(Signed) Lawrence M. D.

Jan 2nd, 1920 (Address) 511 South 3rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.

Modern Pen.	May 5, 1910
-------------	-------------

[illegible]

14 - Mrs. Geo. H. Tenzel & Son 801 W. Fayette St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42789

CERTIFICATE OF DEATH.

64 D42789

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 S. Sharp ST.; 23 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1034 S. Sharp St.; 60 yrs., 5 mos., 1 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Widow

6-DATE OF BIRTH,

Dec. 30th, 1859
(Month) (Day) (Year)

7-AGE,

60 yrs., 5 mos., 1 da.

If LESS than 1 day,

....hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House Duties
at home9-BIRTHPLACE,
(State or Country),

Baltimore Md.

10-NAME OF FATHER,

Michael Lohrmann

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER,

Sabella Ficht

13-BIRTHPLACE OF MOTHER
(State or Country),

Don't know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Katherine Frank

(Address)

1034 S. Sharp St.

15-MAY 3 - 1920

ROBERT F. KRAUTER

Filed....., 191.....

BIRTHAL FINE REGISTERS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 1st, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 20 1920, to May 1 1920, that I saw her alive on April 30 1920, and that death occurred, on the date stated above, at 7:15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration)..... yrs..... mos. 10 da.CONTRIBUTORY
(Secondary)(Duration)..... yrs..... mos. 2 da.(Signed) W. H. M. M. M. M. D.May 1, 1920 (Address) 835 S. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos.da. In the State..... yrs..... mos.da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

May 3, 1920

20-UNDERTAKER

The Mrs. John W. Seufel

ADDRESS

801 N. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42790

CERTIFICATE OF DEATH.

28
REGISTERED No. C

D42790

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 Laurens ST. 16 WARD)

2-FULL NAME Charles W. Stinchcomb

(Residence in Baltimore: No. 1006 Ashburton St.; 3 yrs., 0 mos., 13 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Apr 17, 1917 (Month) (Day) (Year)

7-AGE, 3 yrs., 0 mos., 13 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto. Md.

10-NAME OF FATHER, Chas. N. Stinchcomb

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Emma Heeb

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. N. Stinchcomb

(Address) 1006 Ashburton St.

15-MAY 3 - 1920 ROBERT R. KRAUTER

Burial Permit Registered

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 30, 1920. (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feb 14, 1920, to Apr 30, 1920, that I saw him alive on Apr 29, 1920, and that death occurred, on the date stated above, at 109 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis? unknown (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY Secondary Pneumonia (Secondary) (Duration) ... yrs. ... mos. ... ds.

(Signed) Chas. C. Conser M. D. May 1, 1920 (Address) 1101 N. Fulton A.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. Is the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, May 3, 1920.

20-UNDERTAKER, Mrs. John H. Zupfel & Son, ADDRESS, 801 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42791

CERTIFICATE OF DEATH.

D42791

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes' Hospital* WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD.

(If nonresident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant
(Address)

15

MAY 3 - 1920

ROBERT K. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

April 5, 1920, to May 2, 1920,
that I last saw him alive on May 2, 1920,

and that death occurred, on the date stated above, at 2:00 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pelvic
organs and lower bowels

(duration) 4 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. A 24-14-M. & T.—2000 Hks.

Harriett White

D42792

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42792

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 N Pine ST.; 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 215 N. Pine St.; 46 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE, Col 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, (Month) (Day) (Year)

7-AGE, 50 yrs., mos., ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Hartford Co Md

10-NAME OF FATHER, John Reed

11-BIRTHPLACE OF FATHER (State or Country), Hartford Co Md

12-MAIDEN NAME OF MOTHER, Harriett Reed

13-BIRTHPLACE OF MOTHER (State or Country), Hartford Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lottie Harris

(Address) 215 N. Pine st

15- MAY 3 - 1920

Filed 191... ROBERT H. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 30, 1912 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 28, 1912, to April 30, 1912, that I saw him alive on April 30, 1912, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows: Lobal Pneumonia (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Signed) J. P. S. (Address) 4130 20, 1912 (Address) 113 N. Calver

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

120 Auburn Cem May 3rd 1912

20-UNDERTAKER ADDRESS

A. Jones 207 S. Street

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42793

CERTIFICATE OF DEATH.

39

D42793

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home and Inf. ST.: 4 WARD)

2-FULL NAME

(Residence in Baltimore: No. Hotel Rembert St.: 70 yrs., 1 mos. 28 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, Widowed, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Mar 4, 1899 (Month) (Day) (Year)

7-AGE, 70 yrs., 1 mos., 28 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Salesman 066 (b) General nature of industry, business, or establishment in which employed (or employer), Bush Mfg.

9-BIRTHPLACE, (State or Country), Balto Md.

10-NAME OF FATHER, Edward Raborg

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Ann Rebecca Liversay

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. M. Domes

(Address) 3712 Springdale Ave

15- MAY 3 - 1920 ROBERT R. KRAUTER

Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 2, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 10 1920, to May 2 1920, that I saw him alive on May 2, 1920, and that death occurred, on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Sarcoma of Ovary, Metastasis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Walter T. Anderson M.D.

May 2, 1920 (Address) Church Home and Inf.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Hotel Rembert

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Springdale Ave May 4, 1920

20-UNDERTAKER ADDRESS

Edramblyore 1723 W. Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42794

CERTIFICATE OF DEATH.

REGISTERED NO. C

D42794

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 737 Sarah Ann St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Motilda Cross(Residence in Baltimore: No. 737 Sarah Ann St.; 4 yrs., 4 mos., 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

F

4-COLOR OR RACE

C5-SINGLE, Mar
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

March 10, 1878
(Month) (Day) (Year)

7-AGE,

47 yrs., 1 mos., 21 ds.If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....Domestic
0709-BIRTHPLACE,
(State or Country),Powhatan Va10-NAME OF
FATHER,James Johnson11-BIRTHPLACE
OF FATHER
(State or Country),Va12-MAIDEN NAME
OF MOTHERLama Jane13-BIRTHPLACE
OF MOTHER
(State or Country),Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Lama Rose

(Address).....

737 Sarah Ann St

15-

MAY 3 - 1920ROBERT R. KAUTERBALTIMORE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 1, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 28 1920, to May 1 1920,that I saw h..... alive on April 30 1920,and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

May 1, 1920 (Address) 737 Sarah Ann St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Int. AlhambraMay 4, 1920

20-UNDERTAKER

ADDRESS

R. L. Parlman 131 N. Maryland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42795

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42795

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 706 P. Broadway ST. 2 WARD)

2-FULL NAME Adam Brycko

(Residence in Baltimore: No. 706 P. Broadway

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

May 2, 1920

7-AGE,

Yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Dependent

9-BIRTHPLACE, (State or Country),

Baltimore MD

10-NAME OF FATHER,

Alexander Brycko

11-BIRTHPLACE OF FATHER (State or Country),

Poland

12-MAIDEN NAME OF MOTHER

Barbara Furman

13-BIRTHPLACE OF MOTHER (State or Country),

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alexander Brycko

(Address) 706 P. Broadway

15-

MAY 3 - 1920

ROBERT R. KRAUTER

FILED

REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 3, 1920

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental death

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Shaw M. D.

(Coroner.)

(Address) 1611 N. E. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

May 3, 1920

20-UNDERTAKER

W. H. Falkow, 68 Eastern Ave.

Physicians should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19-H. P. Co. 1000 Ekg.

D42796

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42796

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *7th. General Hospital* ST. *26* WARD)

2-FULL NAME *Miss Viola Gonder*

(a) RESIDENCE. No. *638 S. 15th St.* ST. *15* WARD. *15*
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred *1 1/2* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *John J. Gonder*

6 DATE OF BIRTH (month, day, and year) *June 3 - 1901*

7 AGE Years *18* Months *10* Days *29* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Homework*
(b) General nature of industry, business, or establishment in which employed (or employer) *At Home*
(c) Name of employer *" "*

9 BIRTHPLACE (city or town) (State or country) *Ind*

10 NAME OF FATHER *Robt. Pyle*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ind*

12 MAIDEN NAME OF MOTHER *Molly. Pyle*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ind*

14 Informant *John J. Gonder*
(Address) *638 S. 15th St.*

15 *Fi* *MAY 3 - 1920* *ROBERT B. TRAISTER*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 2, 1920*

17 I HEREBY CERTIFY, That I attended deceased from *Apr 23*, 1920, to *May 2*, 1920, that I last saw her alive on *5/1*, 1920, and that death occurred, on the date stated above, at *8:00 a.m.*
The CAUSE OF DEATH* was as follows:
Pneumonia

(duration) yrs. mos. ds. *10*
CONTRIBUTORY *Pneumonia*
(Secondary) (duration) yrs. mos. ds. *2*

18 Where was disease contracted if not at place of death? *At Home*

Did an operation precede death? *No* Date of *-*

Was there an autopsy? *No*

What test confirmed diagnosis? *Smear & culture*
(Signed) *Chas. G. Smith*, M. D.

. 19 (Address) *7th. General Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

1st. Evangelical *5/4 1920*

20 UNDERTAKER ADDRESS

William F. Galloway 1618 Tasker

D42797

HEALTH DEPARTMENT—CITY OF BALTIMORE D42792

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(n) RESIDENCE. No. Unknown

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE 58 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records

(Address) New City Hospital

MAY 3 - 1920

ROBERT A. KRAUTER

Registrar

Burial Permit 0144

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 19 20

17 I HEREBY CERTIFY, That I attended deceased from April 26, 19 20, to April 29, 19 20.

that I last saw him alive on April 29, 19 20.

and that death occurred, on the date stated above, at 10:15 P. M.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis & Hypertension

unknown (duration) yrs. mos. ds.

CONTRIBUTORY Hemiplegia; cerebral (Secondary) Hemorrhage (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no special test

(Signed) J. F. Pessel, M. D.

Apr 30, 1920 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mathews Cem.

May 3 1920

20 UNDERTAKER

ADDRESS

Philip Henry

2016

Eapre Van Nockey

D42798

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105 D42798
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2115 Druid Hill Ave. 14 St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Eunice Van Nockey
(Residence in Baltimore: No. 2115 V. Hill Ave. St.; yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE, Cal 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH, Jan 22, 1908 (Month) (Day) (Year)

7-AGE, 12 yrs. 3 mos. 8 If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, school-girl (b) General nature of industry, business, or establishment in which employed (or employer), 100

9-BIRTHPLACE, (State or Country), Cal

10-NAME OF FATHER, Geo H Vannackey

11-BIRTHPLACE OF FATHER, MD

12-MAIDEN NAME OF MOTHER, Augusta Burkett

13-BIRTHPLACE OF MOTHER, MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eapre Van Nockey

(Address) 2115 Druid Hill Ave.

MAY 3 - 1920

Filed, 191. ROBERT B. KRAUTER

Burial Permit Report

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 1, 1920 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from April 20, 1920, to May 1, 1920, that I saw her alive on " 191, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

acute gastritis

(Duration) yrs. mos. da.

CONTRIBUTORY Chronic hypoxia, severe

(Secondary) Defect (Duration) yrs. mos. da.

(Signed) E. L. Cardozo M. D.

5-2-20 191... (Address) 152 P. Hill Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. da. In the State, yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, 20-UNDERTAKER

Date of Burial, May 3, 1920

ADDRESS

George H. Holland 1631 Druid Hill Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42799
1-PLACE OF DEATH40 D42799
REGISTERED NO.

CITY OF BALTIMORE: (No. 1522 Linden Ave. ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Hannah Weiller

(a) RESIDENCE. NO.

1522 Linden Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Widowed

5a If married, widowed, or divorced

(or) WIFE of

Charles Weiller (deceased)

6 DATE OF BIRTH (month, day, and year)

Dec 6 1835

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

85

4

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Housewife
Bavaria Germany

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Matthew Steyer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Helen Goodsmith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Alex C. Weiller
1522 Linden Ave

15

Filed

MAY 3 - 1920

ROBERT E. KIMMEL

Burial Permit 6128

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 2 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 4, 1920, to May 2, 1920,

that I last saw him alive on May 2, 1920,

and that death occurred, on the date stated above, at 3:05 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall duct

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

Toxemia of jaundice

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Clinical symptoms

(Signed)

Eugene J. Rapier, M. D.

, 19 (Address)

803 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cheb S. Halom

5/4 1920

20 UNDERTAKER

ADDRESS

H. S. Sondheim

118 W. Mt. Royal Ave.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42800

REGISTERED NO. D42800

PLACE OF DEATH

CITY OF BALTIMORE (No. 2229 Mura St.)

WARD) 8

2-FULL NAME Mary K. Hardy

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2229 Mura St.)

St.; yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Mar*

6-DATE OF BIRTH, January 17, 1920 (Month) (Day) (Year)

7-AGE, 3 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None (b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, Elias R. Hardy

11-BIRTHPLACE OF FATHER, (State or Country), Edgewood Harford Co

12-MAIDEN NAME OF MOTHER, Gertrude E. Ritter

13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elias R. Hardy

(Address) 2229 Mura St

15-

MAY 3 - 1920

ROBERT E. KRAUTER

Burial

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH, May 2, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. G. M. D.

(Address) 1472, 1920

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Abington Harford Co May 3, 1920

20-UNDERTAKER

Henry Lutz

ADDRESS

1007 N. Bond St

D42801

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42801

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

University Hospital

St.:

27

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Jm. J. Marran

(Residence in Baltimore: No.

215 Belvidere av-

St.; yrs., life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Oct 26, 1870

(Month)

(Day)

(Year)

7-AGE,

49 yrs. 6 mos. 6 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Merchant

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Balt Md.

10-NAME OF FATHER,

Jm. J. Marran

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Rose Kelly

13-BIRTHPLACE OF MOTHER

(State or Country),

Balt Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Marran

(Address)

215 Belvidere Ave

15-

MAY 3 - 1920

ROBERT B. KRAUTER

Filed

101

Baltimore

City

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 1, 1920

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Favorable disease of the heart

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. R. G. M. D.

5. 3. 1912

Address

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

10-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Cathedral Cemetery

May 4, 1920

20-UNDERTAKER

ADDRESS

Robert J. Turner 1912 W. R. R.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 8 WARD)

2-FULL NAME

Anna M. Koeck

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

(Usual place of abode) 1209 N. Dork Ave. WARD. (If nonresident, give city or town and State)Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

unknown6 DATE OF BIRTH (month, day, and year) 18557 AGE Years Months Days If LESS than 1 day, hrs. or min. 65

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14

Informant (Address)

15

MAY 3 - 1920ROBERT F. LEAUTE
Registrar

Burial Permit Closed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-7 19 2017 I HEREBY CERTIFY, That I attended deceased from 4-16, 19 20, to 5-1, 19 20, that I last saw her alive on 5-1, 19 20.and that death occurred, on the date stated above, at 7:47 p.m.

The CAUSE OF DEATH* was as follows:

Disseminated Pulmonary Tuberculosisunknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

unknown (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? cityDid an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? no special test(Signed) J. P. Pessel, M. D.

5-1, 1920 (Address)

Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer CemeteryMay 4 19 20

20 UNDERTAKER

Henry Horck Sur

ADDRESS

1301 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D42803

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D42803

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1242 Columbia St. WARD 9)2-FULL NAME Bridget A. Holt(a) RESIDENCE. NO. 1242 Columbia St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Holt6 DATE OF BIRTH (month, day, and year) 18617 AGE Years 59 Months - Days - If LESS than 1 day, hrs. - or min. -

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) 000(c) Name of employer -9 BIRTHPLACE (city or town) Ireland (State or country)10 NAME OF FATHER Patrick Malon11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)14 Informant Mr. Chas W. Fenwick (Address) 1242 Columbia Ave.15 Filed MAY 3 1920 ROBERT E. KRAUTER Registrar Burial Permit 0121

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-2- 192017 I HEREBY CERTIFY, That I attended deceased from April 20, 1920, to May 2, 1920, that I last saw her alive on May 2, 1920, and that death occurred, on the date stated above, at 8 a m. The CAUSE OF DEATH* was as follows:Broncho Pneumonia.CONTRIBUTORY (duration) yrs. mos. ds. 5 (Secondary) Acute Bronchitis, old type (duration) yrs. mos. ds. 3

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen A. Dray M. D. , 19 (Address) 1227 Columbia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Cathedral Cem 5/5/ 1920

20 UNDERTAKER ADDRESS

John J. Howard & Son goldblum

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D42804

CERTIFICATE OF DEATH.

82 D42804

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 E. 35 ST.;

WARD) 9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Young Rhoads(a) RESIDENCE. No. 708 E 35 ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F4 COLOR OR RACE W5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed6 DATE OF BIRTH (month, day, and year) unk

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. about 85

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)10 NAME OF FATHER John Hollingshead11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)12 MAIDEN NAME OF MOTHER Rebecca13 BIRTHPLACE OF MOTHER (city or town) unk
(State or country)

14

Informant Mrs Cushing
(Address) 708 E 35 St.

15

Filed

MAY 3 - 1920

ROBERT E. KRAUTER
Registrar

Serial 111111

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 2 1920 to May 2 1920that I last saw him alive on May 2 1920and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis(duration) yrs. mos. 2 1/2 ds.CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? —(Signed) B. K. Kelly M. D., 19 (Address) 3522 Old York Rd

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park CemeteryDATE OF BURIAL May 3 192020 UNDERTAKER H. E. HughesADDRESS 17 S. Howard St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42805

CERTIFICATE OF DEATH.

91 D42805

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1840-N. Caroline ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Gross(a) RESIDENCE. No. 1840-N. Caroline ST., 9 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
------------------------	---------------------------------	---

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of no6 DATE OF BIRTH (month, day, and year) Apr 12/1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<u>1</u>	<u>1</u>	<u>20</u>	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) none(c) Name of employer none9 BIRTHPLACE (city or town) Balto.
(State or country) md10 NAME OF FATHER Fredrick Gross11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)12 MAIDEN NAME OF MOTHER Elizabeth Bock13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)14 Informant Mrs. Fredrick Gross
(Address) 1840-N. Caroline St.15 File MAY 3 - 1920 ROBERT K. RAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr May 192017 I HEREBY CERTIFY, That I attended deceased from Apr 27, 1920, to May 2, 1920.that I last saw him alive on May 1, 1920.and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

acute Berylliosis
(or chronic Pneumonia)6 d (duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? none(Signed) W. S. Riley, M. D.. 19 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Carmel CemeteryMay 4 1920

20 UNDERTAKER

ADDRESS

George F. Rutter1735 Haverford

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D42806

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42806

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *7* WARD)2-FULL NAME *Walter Vohs (Vohs)*(a) RESIDENCE. No. *609 1/2 Robinson* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

*white*5 Single, Married, Widowed,
or Divorced (write the word)*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Mar 3 1904*

7 AGE

15

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant
(Address)

15

MAY 3 - 1920

ROBERT S. KRAUTER
Registrar

REGISTERED No.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 1* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

4/15 19*20*, to *5/1* 19*20*,that I last saw him alive on *5/1* 19*20*,and that death occurred, on the date stated above, at *340* p.m.

The CAUSE OF DEATH* was as follows:

*Acute gangrenous Appendicitis
& General Peritonitis*(duration) yrs. mos. *20* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed) *C. K. Schuchman* M.D.(Address) *University Hospital**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Goodland Ave**May 1920*

20 UNDERTAKER

ADDRESS

W. J. Schuchman for Reman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42807

CERTIFICATE OF DEATH.

64 D42807
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 Poplar Grm ST.; 16 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1207 Poplar Grm St.; 77 yrs., 7 mos. 25 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Widowed

6-DATE OF BIRTH.

Sept 5th, 1842
(Month) (Day) (Year)

7-AGE,

77 yrs., 7 mos. 25 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Pharmacist
025

9-BIRTHPLACE,

(State or Country).

Eastern Shore Md.

10-NAME OF FATHER,

Gentry Robinson

11-BIRTHPLACE OF FATHER

(State or Country), Eastern Shore Md.

12-MAIDEN NAME OF MOTHER

Annin - unknown -

13-BIRTHPLACE OF MOTHER

(State or Country), Eastern Shore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

MAY 3 - 1920

191

COUNTY & EXEMPTED

Social Permit Registered

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 30th, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 26, 1920, to April 30, 1920, that I saw him alive on April 30th, 1920, and that death occurred, on the date stated above, at 12:30 P.

The CAUSE OF DEATH* was as follows:

Apoplexy -

* (Duration) ... yrs. ... mos. ... ds. 4 1/2

CONTRIBUTORY... (Secondary)

(Duration) ... yrs. ... mos. ... ds. 2 1/2

(Signed) ... M. D.

Apr. 30th, 1920 (Address) 1207 Poplar Grm

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western

DATE OF BURIAL,

May 3, 1920

20-UNDERTAKER

W. J. Dickerson

ADDRESS

N. Y. Pa

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42808

CERTIFICATE OF DEATH.

64

D42808

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3927 Park Heights Ave. ST.: 15 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 3927 Park Heights ST. 15 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Beeli6 DATE OF BIRTH (month, day, and year) Mar 23 - 18427 AGE Years 78 Months 1 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER John Blather11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland12 MAIDEN NAME OF MOTHER Blather13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

PARENTS

14 Informant (Address) 3927 Park Heights

15

MAY 3 - 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 192017 I HEREBY CERTIFY, That I attended deceased from April 25, 1920 to May 1st, 1920, that I last saw her alive on May 1st, 1920, and that death occurred, on the date stated above, at about 6 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy -

CONTRIBUTORY (Secondary)

(duration) see above yrs. mos. ds.(duration) ? yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. P. Wise

, 19

(Address) Pikesville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D42809

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D42809

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2850 Woodbrook Ave ST.; 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Albert H Jacobson(Residence in Baltimore: No. 2850 Woodbrook Ave St.: 4 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

July 21, 1850
(Month) (Day) (Year)

7-AGE,

70 yrs., 9 mos., 12 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

EditorNews paper

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Don't know

11-BIRTHPLACE OF FATHER (State or Country),

Don't know

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER (State or Country),

Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Aldena Jacobson

(Address)

2850 Woodbrook Ave

15-

Filed

MAY 3-1920

191

ROBERT B. RAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 2, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 1919, to May 1 1920, that I saw him alive on May 1 1920, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Simultaneous Myocardial(Duration) 8 yrs., 4 mos., ds.

CONTRIBUTORY (Secondary)

Exhaustion(Duration) yrs., mos., ds.(Signed) Frank B. Jewett M. D.May 2, 1920 (Address) 2516 Penn. Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hebrew Fund ShipMay 4 1920

20-UNDERTAKER

ADDRESS

Josiah Syfer 1600 N North Ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42810

D42810

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 Brentwood Ave ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 1108 Brentwood Ave ST., 10 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Cavanaugh6 DATE OF BIRTH (month, day, and year) 22 July 18327 AGE Years 87 Months 9 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Watertown, N. Y. (State or country) Jefferson Co.10 NAME OF FATHER Thomas Bellin11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland12 MAIDEN NAME OF MOTHER Ann Coyne13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland14 Informant Mrs. Thos. M. Grant (Address) 1108 Brentwood Ave15 MAY 3 - 1920 ROBERT B. RAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 192017 I HEREBY CERTIFY, That I attended deceased from April 6, 1920, to May 1, 1920, that I last saw him alive on May 1, 1920, and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Fracture of R Femur by falling from floor
Accident(duration) yrs. mos. 22 ds.CONTRIBUTORY Hypertension (duration) yrs. mos. 1 ds.18 Where was disease contracted if not at place of death? 1108 Brentwood AveDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) James M. Fenton M. D.Address 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Cem

20 UNDERTAKER

Henry H. Jenkins Sons

DATE OF BURIAL

May 4th 1920

ADDRESS

McNeill's
Richard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D42811

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42811

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

904 Bolton

ST. 11 WARD)

REGISTERED NO. C

2-FULL NAME

Dorothy R. Taylor

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

904 Bolton St. 11 weeks

yrs. 1 mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female Colored

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

March 20, 1920
(Month) (Day) (Year)

7-AGE,

yrs. 1 mos. 11 ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

MAY 3 - 1920

ROBERT E. LEAUTE

191

Burial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr 30, 1920, to Apr 30, 1920,

that I saw her alive on April 30, 1920,

and that death occurred, on the date stated above, at 5-15 P.M.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(Duration)....yrs. 11 mos. 11 ds.

CONTRIBUTORY
(Secondary)

(Duration)....yrs.mos.ds.

(Signed) Samuel Fargo M. D.

May 2, 1920 (Address) 746 Bolton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs.mos.ds. In the State yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

The Auburn Co. May 3, 1920

20-UNDERTAKER

ADDRESS

Samuel Fargo 518 N. E. St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42812

CERTIFICATE OF DEATH.

91

D42812

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 17

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Elizabeth Smith

(Residence in Baltimore: No.

522 Dolphin

St. 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

50

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

070

9-BIRTHPLACE,

(State or Country),

Va.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

James H. Smith

(Address)

522 Dolphin St.

15-

FILED MAY 3 - 1920

ROBERT B. REAUTE

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May - 1 - 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr - 24, 1920, to Apr 30 1920, that I saw her alive on Apr 30 1920, and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Duration) yrs. mos. ds. 6

CONTRIBUTORS (Secondary)

(Duration) yrs. mos. ds. 4

(Signed) J. B. Hughes M. D.

Apr 30 1920 (Address) 1413 1st St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. 1 In the State yrs. mos. ds. 1

Where was disease contracted, if not at place of death? 522 Dolphin St

Former or usual residence 522 Dolphin St

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Aurel St. May 3, 1920

20-UNDERTAKER

ADDRESS

Samuel J. Husley 578 N. Biddle

Important. See instructions on back of certificate.

D42813

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42813

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 W. MohrST.: 14 WARD) 91

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Archer Thomas(Residence in Baltimore: No. 422 W. MohrSt.: 27 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Male</u>	4-COLOR OR RACE, <u>Colored</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <u>Married</u>
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6-DATE OF BIRTH, <u>March</u> , <u>1837</u>
(Month) (Day) (Year)

7-AGE, <u>83</u> yrs. — mos. — ds.	If LESS than 1 day,hrs. ormin.?
---------------------------------------	--

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).	<u>Door man</u> <u>Merchant's Club</u>
--	---

9-BIRTHPLACE, (State or Country), <u>Richmond Va</u>
--

10-NAME OF FATHER, <u>William Thomas</u>

11-BIRTHPLACE OF FATHER (State or Country), <u>Virginia</u>

12-MAIDEN NAME OF MOTHER <u>Sallie Floyd</u>

13-BIRTHPLACE OF MOTHER (State or Country), <u>Virginia</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas G. Gorman(Address) 241 N. Lombard St. Baltimore, Md.

15- MAY 3 - 1920	ROBERT B. BAUTER
Filed	191

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, <u>May 12</u> , <u>1920</u>
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 3 1920, to May 12 1920, that I saw him alive on April 29 1920, and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

<u>Pneumonia</u> (Duration) <u>3</u> yrs. <u>3</u> mos. <u>3</u> ds.
--

CONTRIBUTORY (Secondary) <u>Pneumonia</u>

<u>Schistosomiasis</u> (Duration) <u>3</u> yrs. <u>3</u> mos. <u>3</u> ds.
--

(Signed) Edmund E. Mackenzie M. D.May 2, 1920. (Address) 1339 W. North St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.
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Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Ambrose ChurchDATE OF BURIAL, May 3, 192020-UNDERTAKER, Samuel H. HensleyADDRESS, 578 N. Biddle

important. See instructions on back of certificate.

D42814

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D42814

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

1437 Laurens

ST. 16

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles Thomas Henson

(a) RESIDENCE. No.

1437 Laurens

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Ethel Henson

6 DATE OF BIRTH (month, day, and year)

Sept 23, 1894

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

25

7

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Usher - Assistant

(b) General nature of industry, business, or establishment in which employed (or employer)

managing City of Baltimore
Seating people etc.

(c) Name of employer

J. C. Crumley

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Charles Wesley Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

West River

A. A. Co. Md.

12 MAIDEN NAME OF MOTHER

Rose Etta Dennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

West River

Maryland

14

Informant

(Address)

Ethel Henson

1437 Laurens St

15

MAY 3 - 1920

ROBERT B. LAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

April 30 1920

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 28, 1919, to April 30, 1920.

that I last saw him alive on April 29, 1920.

and that death occurred, on the date stated above, at 2:35 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

None.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

U. S. Army.

Did an operation precede death?

No

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Physical Specimen

(Signed)

William N. Hughes, M. D.

21, 1920 (Address)

1209 Preston Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

M. A. Church

MAY 3 - 1920

20 UNDERTAKER

ADDRESS

JAMES H. DENNIS

1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D42815

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42815

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1508 Prestman*ST.: *15* WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Samuel Coleman(a) RESIDENCE, NO. *1508 Prestman*

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

3

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col.

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Boca, Md

10 NAME OF FATHER

Andrew Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ferguson

12 MAIDEN NAME OF MOTHER

Geneva Cornish

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Boca, Md

14

Informant (Address)

Geneva Cornish 1508 Prestman St

MAY 3 - 1920

ROBERT H. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Apr. 30* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

*Apr 27, 1920, to Apr 30, 1920,*that I last saw him alive on *Apr 30, 1920,*and that death occurred, on the date stated above, at *9:45 P. m.*

The CAUSE OF DEATH* was as follows:

Utelectasis(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Paul Brown*, M. D., 19 (Address) *1837 Penna Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Peters

MAY 3

-1920

19

20 UNDERTAKER

JAMES H. DENNIS

ADDRESS

1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42816

D42816

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *2423 monument* ST. *7* WARD)

2-FULL NAME *Doris Bear*

(Residence in Baltimore: No. *2423 monument* St. *40* yrs., *40* mos. *40* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *wh* 5-SINGLE *Married* MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, *Jan 12*, 18*65* (Month) (Day) (Year)

7-AGE, *55* yrs., *3* mos., *19* ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Baker* (b) General nature of industry, business, or establishment in which employed (or employer), *003*

9-BIRTHPLACE, (State or Country), *Germany*

PARENTS. 10-NAME OF FATHER, *Henry Bear* 11-BIRTHPLACE OF FATHER (State or Country), *Germany* 12-MAIDEN NAME OF MOTHER, *Unknown* 13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) *Elizabeth Bear* (Address) *2423 monument*

15- *MAY 3 - 1920* *ROBERT S. KRAUTER* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 1*, 19*20* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows:

Diabetes (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (Signed) *Wm. J. Foster* M. D. (Coroner) *Wm. J. Foster* (Address) *58 E. 1st*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place *of death* In the *State* of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds. Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cemetery* DATE OF BURIAL, *May 4*, 19*20*

20-UNDERTAKER, *Mrs. C. Miller* ADDRESS, *2334 Jefferson*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1742812

CERTIFICATE OF DEATH.

1742812
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *12 Psych Hospital* ST. *26* WARD)

2-FULL NAME

Wilhelm Paul

(Residence in Baltimore: No.

614 S 16th St

St. *3* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)

6-DATE OF BIRTH, *March 25, 1884* (Month) (Day) (Year)

7-AGE, *36* yrs. *1* mos. *5* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Painter* (b) General nature of industry, business, or establishment in which employed (or employer), *050*

9-BIRTHPLACE, (State or Country), *Germany*

10-NAME OF FATHER, *not known*

11-BIRTHPLACE OF FATHER (State or Country), *not known*

12-MAIDEN NAME OF MOTHER, *not known*

13-BIRTHPLACE OF MOTHER (State or Country), *not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Willie C. Paul*

(Address) *614 S. 16th St.*

15-

Filed *MAY 3 - 1920* 101... *ROBERT L. LEVITT* Registrar.

Serial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 2, 1920* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said... (Inquest, au-

topsy or inquiry) and that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic fall off ladder at 3:15 P.M.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Frank Smiley* M. D. (Coroner)

191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cem* DATE OF BURIAL, *May 5, 1920*

20-UNDERTAKER, *Gutkin & Gutkin* ADDRESS, *1739 E. Egan St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42818

D42818

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

1614 E. Chase St.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

1614 E. Chase St.

WARD)

2-FULL NAME

Cora Evelyn Stockham

(a) RESIDENCE.

No. 1614 E. Chase St.

WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred

30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

Female White Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1873

7 AGE

47

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

House work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Perryville Md

10 NAME OF FATHER

John Quincy Stockham

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Louise Roy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Maryland

14

Informant
(Address)William Stockham,
1081 N. Broadway

15

Filed

MAY 3 - 1920

ROBERT B. KAUTER

Registrar

Burial Permit 01070

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 1 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 23, 1920, to May 1, 1920,

that I last saw her alive on May 1, 1920,

and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Intracranial
Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Arterio-sclerosis of heart

(duration) 4 yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no test

(Signed) W. M. Donald, M. D.

(Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Perriman Hazard & Co. MA

May 5 1920

20 UNDERTAKER

Joseph Abrams

224 N. Broadway

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42819

CERTIFICATE OF DEATH.

79 6 D42819
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 N Broadway ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Louis V Holter

(Residence in Baltimore: No. 408 N Broadway St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Widower

6-DATE OF BIRTH.

2 14 1880
(Month) (Day) (Year)

7-AGE.

80 yrs. 2 mos. 16 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None
ooo9-BIRTHPLACE,
(State or Country),

Pa

10-NAME OF FATHER,

Louis V Holter

11-BIRTHPLACE OF FATHER
(State or Country),

Pa

12-MAIDEN NAME OF MOTHER

Anna Rats

13-BIRTHPLACE OF MOTHER
(State or Country),

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis V. Holter

(Address) 408 N Broadway

15-

MAY 3 - 1920

ROBERT B KRAUTER

Burial Permitted

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5 2 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

4-27 1920, to 5-2 1920,

that I saw him alive on 4-27 1920,

and that death occurred, on the date stated above, at 2:50 p.m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Elijah J. Russell M. D.

5-2 1920 (Address) 156 N. Milton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn Cemetery

DATE OF BURIAL,

May 4, 1920

20-UNDERTAKER

Joseph Abrams

ADDRESS

2217 Broadway

important. See instructions on back of certificate.

D42820

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42820

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 N. Gilman ST.; 15 WARD)

REGISTERED NO. C.

2-FULL NAME

(Residence in Baltimore: No. 1626 N. Gilman St.; 3 yrs., — mos., — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, widow
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

August 15th, 1837
(Month) (Day) (Year)

7-AGE,

82 yrs., 8 mos., 17 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)ret. army
10009-BIRTHPLACE,
(State or Country),County Cork Ireland

10-NAME OF FATHER,

Orren Lafferty11-BIRTHPLACE OF FATHER
(State or Country),County Cork Ireland

12-MAIDEN NAME OF MOTHER

Mary Ann O'Brien13-BIRTHPLACE OF MOTHER
(State or Country),County Cork Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) (Mrs) Mary Ann Giffen(Address) 1626 N. Gilman St

15-

Robert P. Harrison,

Filed 1920

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 2nd, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 30th 1919, to May 2nd 1920, that I saw h. alive on May 2nd 1920, and that death occurred, on the date stated above, at 11:25 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis(Duration) 1 yrs., 6 mos., — ds.CONTRIBUTORY... Chronic Bronchitis
(Secondary)(Duration) 1 yrs., 10 mos., — ds.(Signed) Wm. J. Giffen M. D.
5/3, 1920 (Address) 1701 N. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Flower Dr. Grace Rd

DATE OF BURIAL,

5-5th, 1920

20-UNDERTAKER,

Ed B. Clarke

ADDRESS

115 E. West St

D42822

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42822

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 9th ST.; 2 WARD)2-FULL NAME Joseph L. Vanhatten(Residence in Baltimore: No. 1732 9th St.; yrs., mos., ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M 4-COLOR OF RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Jan 3, 1911.
(Month) (Day) (Year)

7-AGE, 4 yrs., 0 mos., 0 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Doc
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balt

10-NAME OF FATHER, Marshall Vanhatten

11-BIRTHPLACE OF FATHER (State or Country), Balt

12-MAIDEN NAME OF MOTHER Staten Rein

13-BIRTHPLACE OF MOTHER (State or Country), Blt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marshall Vanhatten

(Address) 1732 9th St.

15-

Robert P. Harrison, 191. Registrar.

Filed AY 3-1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 3, 1920.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to May 3, 1920, that I saw him alive on May 3, 1920, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Brain pneumonia
(Duration) 3 yrs., 0 mos., 0 ds.

CONTRIBUTORY (Secondary) None

(Duration) 3 yrs., 0 mos., 0 ds.

(Signed) J. Harrison M. D.

May 3, 1920. (Address) 1600 Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 yrs., 0 mos., 0 ds. In the State 3 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Public Cross Cemetery

DATE OF BURIAL, May 4, 1920.

20-UNDERTAKER Sheddell & Sons

ADDRESS 1500 Ave. 6

D42823

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42823

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Josephs Hosp 26* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *Franklin Ave Belair Blvd.*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>white</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Married</i>
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5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Married*6 DATE OF BIRTH (month, day, and year) *1875 March 21*

7 AGE <i>45</i>	Years <i>45</i>	Months <i>1</i>	Days <i>11</i>	If LESS than 1 day, hrs. or min.
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8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Florist 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Gardenville*
(State or country) *Maryland*10 NAME OF FATHER *Joseph Smith*11 BIRTHPLACE OF FATHER (city or town) *Luxemburg*
(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Elizabeth Prosser*13 BIRTHPLACE OF MOTHER (city or town) *Gardenville*
(State or country) *Maryland*14 Informant *Katherine Smith*
(Address) *Gaspar, Ind.*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 2nd 1920*

17 I HEREBY CERTIFY, That I attended deceased from *May 1st*, 1920, to *May 2nd*, 1920, that I last saw him alive on *May 2nd*, 1920, and that death occurred, on the date stated above, at *3:30 P. m.*

The CAUSE OF DEATH* was as follows:

Myocardial infarction(duration) yrs. mos. *1* ds.

CONTRIBUTORY (Secondary)

infarction of stomach
(duration) yrs. mos. *2* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *yes* Date of *May 1st 1920*Was there an autopsy? *no*What test confirmed diagnosis? *Biopsy of stomach*
(Signed) *J. T. D. ...* M. D.19 (Address) *St Josephs Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Cemetery May 6 1920*20 UNDERTAKER *Frank Lassusmaison* ADDRESS *Fullerton*

TION is very important. See instructions on back of certificates.

MAY 3 - 1920

Burial Permit Clerk

Registrar

D42824

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D42824
REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

female

4-COLOR OR RACE,

black

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

not obtained

....., 1
(Month) (Day) (Year)

7-AGE,

about

1 yrs. 5 mos. da.

If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Baltimore Md.

PARENTS.

10-NAME OF FATHER,

John Ross

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Laura Davis

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Robert P. Harrison

UNIVERSITY OF MARYLAND

Filed, 191.....

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April

30

191²⁰

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Feb

191²⁰

to

April 30

191²⁰

that I saw h or alive on

April 30

191²⁰and that death occurred, on the date stated above, at 10³⁰ a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration)..... yrs. mos. ds.

CONTRIBUTORY.....
(Secondary)

Malnutrition

(Duration)..... yrs. mos. ds.

(Signed)..... M. D.

May 1, 191²⁰ (Address)..... 2005 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Commissioner Health

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42825

CERTIFICATE OF DEATH.

152 D42825
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 554 N. Connaway ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 554 Connaway Street St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

April 26, 1920
(Month) (Day) (Year)

7-AGE,

4 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Baltimore Md.

10-NAME OF FATHER,

William Goodman

11-BIRTHPLACE OF FATHER
(State or Country),

Ohio

12-MAIDEN NAME OF MOTHER

Frances Pierce

13-BIRTHPLACE OF MOTHER
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed 1920 Robert P. Harrison,

Registrar.

Burial Permit Clerk.

17175

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 26, 1920, to April 30, 1920, that I saw her alive on April 30, 1920, and that death occurred, on the date stated above, at 2:40 P.M.

The CAUSE OF DEATH* was as follows:

Haemorrhage - (Uterine cap.)
(Haemophilus)
(Duration)..... yrs. mos. ds.CONTRIBUTORY
(Secondary)(Signed) R. C. Deitz M. D.
4/30, 1920 (Address) Union Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Commissioner Health.

Wm. E. WOODALL

MAY 3 - 1920

D42826

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42826

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Agel Man Home* ST.; *19* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1400 W Lexington* St.; *66* yrs., *1* mos., *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

M

4-COLOR OR RACE.

*W*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Mar*

6-DATE OF BIRTH.

Mar 29, *1884*
(Month) (Day) (Year)

7-AGE.

66 yrs., *1* mos., *4* ds.

If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Balt

10-NAME OF FATHER,

Jos Beebe

11-BIRTHPLACE OF FATHER (State or Country),

England

12-MAIDEN NAME OF MOTHER

Rachel Roberts

13-BIRTHPLACE OF MOTHER (State or Country),

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *H. M. Gellman*(Address) *Mt Air*

15-

MAY 3 1926 *191* *Robert P. Harrison,*
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 3, *1926*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr 13 *1926*, to *May 3* *1926*.that I saw h..... alive on *May 2* *1926*.and that death occurred, on the date stated above, at *5 A* m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) yrs. mos. *21* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. *7* ds.(Signed) *J. J. Harrison* M. D.*May 3*, *1926* (Address) *739 W Fayette*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *10* yrs. mos. ds. In the State yrs. mos. ds.Where was disease contracted, if not at place of death? *at the home*

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

St. Mary's Cemetery

DATE OF BURIAL,

May 6, *1926*

20-UNDERTAKER

Geo J Smith

ADDRESS

1000 W Fayette

D42827

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42827

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *108 W. Lee* ST. *22* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Timothy J. Moran

(a) RESIDENCE. NO.

*108 W. Lee*ST. *2-2* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *53* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Florence A. Moran

6 DATE OF BIRTH (month, day, and year)

Sep 22 1866

7 AGE

*53**7**8*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

Balto American

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

James Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Bridget Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Florence A. Moran
*108 W. Lee St**Robert F. Harrison,*

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/1/20* 19

17

HEREBY CERTIFY, That I attended deceased from *4/18/20*, 19, to *5/1/20*, 19, that I last saw him alive on *5/1/20*, 19, and that death occurred, on the date stated above, at *9 am* m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic interstitial nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

Examination

(Signed)

J. Harrison

M. D.

, 19

1072 West St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral Cem**May 4 1920*

20 UNDERTAKER

ADDRESS

*Fred A. Spaul & Son**139 Hanover*

TION is very important. See instructions on back of certificates.

MAY 9 1920

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1042828

105 1042828

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 708 South Bond

ST.: 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME MARY SLIWINSKA,

(Residence in Baltimore: No. 708 South Bond

80 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female, 4-COLOR OR RACE, White, 5-SINGLE, MARRIED, widow, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 78 yrs. 0 mos. 0 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, At Home, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Poland,

10-NAME OF FATHER Adam Markuszewski,

11-BIRTHPLACE OF FATHER (State or Country), Poland,

12-MAIDEN NAME OF MOTHER Regina *****

13-BIRTHPLACE OF MOTHER (State or Country), Poland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Waleria Rokowska,

(Address) 708 So. Bond Street.

15- Robert P. Harrison, Registrar.

May 2 - 1920 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH May 3, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: acute gas pneumonia (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (Duration) ... yrs. ... mos. ... ds. (Signed) Cherry Spaulding M. D. (Coroner.) 191 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary Ann, DATE OF BURIAL, May 5, 1920

20-UNDERTAKER M. F. Sadowski, ADDRESS

D42829

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42829

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

Monument St. 15

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mrs. Frances Baranaski

(Residence in Baltimore: No.

2207 Ellamont St

St.; 24 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. Female	4-COLOR OR RACE. White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married
6-DATE OF BIRTH. August 15, 1896 (Month) (Day) (Year)		
7-AGE. 24 yrs. 8 mos. 19 ds. If LESS than 1 day, ... hrs. or ... min.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Office typist 086		

9-BIRTHPLACE.
(State or Country),

Baltimore, Md.

PARENTS.

10-NAME OF FATHER,

John Machulez

11-BIRTHPLACE OF FATHER
(State or Country),

Poland

12-MAIDEN NAME OF MOTHER

Annie Hilla

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Annie Machulez, Mother

(Address)

628 S. Bond St.

15-

Robert P. Harrison

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

(Month)

3rd

(Day)

1920

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 3, 1920, to May 3, 1920

that I saw her alive on May 3, 1920,

and that death occurred, on the date stated above, at 6:00 p.m.

The CAUSE OF DEATH* was as follows:

Pulvic Peritonitis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

General Septicemia

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

Hebrew Hospital
May 3, 1920 (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Polish Holy Cross Cem.

DATE OF BURIAL,

May 6, 1920

20-UNDERTAKER

M. J. Sadowski

ADDRESS

405 S. Ann St.

MAY 3 - 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42830

CERTIFICATE OF DEATH.

104
REGISTERED NO. C

D42830

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Nursery & Child Hospital* ST. *18* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Nursery & Child Hospital* St. *18* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*Italian White*5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Infant

6-DATE OF BIRTH,

Oct. 10, 1919
(Month) (Day) (Year)

7-AGE,

6 yrs. 7 mos. 23 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None
*000*9-BIRTHPLACE,
(State or Country),*md.*

10-NAME OF FATHER,

*Chas Barbara*11-BIRTHPLACE OF FATHER
(State or Country),*Italy*

12-MAIDEN NAME OF MOTHER

*unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

G. Barbara

(Address)

925 N Rose St.

15-

MAY 4 - 1920

ROBERT E KRAUTER

Filed

191

BALTIMORE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 4, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Apr. 30, 1920, to May 4, 1920,*that I saw her alive on *May 4, 1920,*and that death occurred, on the date stated above, at *4 A. m.*

The CAUSE OF DEATH* was as follows:

Acute intestinal intoxication

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

J. J. Feinglass M. D.
May 4, 1920 (Address) 2002 E. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St Vincent Cemetery

DATE OF BURIAL,

May 4, 1920

20-UNDERTAKER

George J. Ruth

ADDRESS

1735 Hayford Ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42831

CERTIFICATE OF DEATH.

64 D42831

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2018 Beechway ST. 15 WARD)

2-FULL NAME

Thomas J. Helech

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2018 Beechway - St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

married

6-DATE OF BIRTH,

Month Day Year

7-AGE,

60

IF LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

stone mason

(b) General nature of industry, business, or establishment in which employed (or employer).

075

9-BIRTHPLACE, (State or Country),

Balto md.

PARENTS.

10-NAME OF FATHER,

Michael Helech

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Mary McCrathy

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Munn

(Address) 1516 John St.

15 MAY 4 - 1920

ROBERT K. KRAUTER

Filed

191

BURIAL

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 2, 1920

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, thereon and from the evidence obtained by said inquest, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: apoplexy.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. E. Smith M. D. 5/3/20 (Address) 1010 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

St. Peters

DATE OF BURIAL,

May 4, 1920

20-UNDERTAKER

Arthur Fahy - Sons

ADDRESS

1827 N. 1st St.

D42832

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37

D42832

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mount Hope Retreat* ST.; *V* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Henry Somniski*(Residence in Baltimore: No. *224 S. Washington St.* St.; *Don't Know* yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

December

(Month)

18

(Day)

1888

(Year)

7-AGE,

*32**4**21*

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Machinist - Hand**Machine -*9-BIRTHPLACE,
(State or Country),*Baltimore Md*

10-NAME OF FATHER,

*Laurance Somniski*11-BIRTHPLACE OF FATHER
(State or Country),*Poland*

12-MAIDEN NAME OF MOTHER

*Josephine Poppel*13-BIRTHPLACE OF MOTHER
(State or Country),*Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Nawojenski, Janowski

(Address)

224 S. Washington St.

15-

MAY 4 - 1920

ROBERT H. KRAUTER

Filed

Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Feb 14 1920**1920**191*

that I saw him alive on

*Feb 2**191*and that death occurred, on the date stated above, at *7:40* m.

The CAUSE OF DEATH* was as follows:

*Foresis - (Eclampsia)**Abt.*

(Duration)

1

yrs.

0

mos.

5

ds.

CONTRIBUTORY

Mania Depressio

(Secondary)

Abt.

(Duration)

1

yrs.

0

mos.

0

ds.

(Signed)

Frank J. Flannery

M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

of death

0

yrs.

2

mos.

0

ds.

In the

State

0

yrs.

2

mos.

0

ds.

Where was disease contracted, if not at place of death?

Baltimore Md -

Former or

usual residence

Baltimore Md

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

5/4

ADDRESS

20-UNDERTAKER

*William Gialkowski**168 E. Evers*

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42833

CERTIFICATE OF DEATH.

79
REGISTERED NO. C

D42833

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 N. Mount St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1717 N. Mount St.; 45 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *H.* 4-COLOR OR RACE, *W.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *January 1, 1858*
(Month) (Day) (Year)7-AGE, *62 yrs. 4 mos. da.* If LESS than 1 day,hrs. ormin.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Wife*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Ireland*10-NAME OF FATHER, *Hugh Mahony*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER, *Catherine Kerrigan*13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert H. Keaster*(Address) *1717 N. Mount St.*

15- MAY 4 - 1920

101- ROBERT H. KEASTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 2, 1920*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Nov 12, 1919*, to *May 1, 1920*, that I saw her alive on *May 1, 1920*, and that death occurred, on the date stated above, at *3 a.* m. The CAUSE OF DEATH* was as follows:*Val. Heart Disease*
(Duration) *8* yrs., mos., ds.CONTRIBUTORY (Secondary) *Smoking*
(Duration) *8* yrs., mos., ds.(Signed) *Wm. Wright* M. D.
May 3rd, 1920 (Address) *1801 St. Paul*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death,yrs.,mos.,ds. In the State,yrs.,mos.,ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Johns Valley Longview* DATE OF BURIAL, *May 5, 1920*20-UNDERTAKER, *Robt. Keaster* ADDRESS, *1427 N. Broadway*

D42834

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42834

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from Apr 18 1920, to May 1 1920, that I saw h alive on Apr 30 1920, and that death occurred, on the date stated above, at 09 m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from bursting of varicose veins in leg.

CONTRIBUTORY
(Secondary)Varicose veins.
(Duration) 2 yrs. mos. ds.
(Signed) Geo. K. L. M. D.
May 1 1920 (Address) 3035 S. Downell St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

MAY 4 - 1920

ROBERT B. KRAUTER

Filed... IDL... Baltimore City

St Pauls. Cem. May 5, 1920
H. Sander Saus 1710 N. 1st St.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42835

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

USA General Hospital No.2,

REGISTERED NO. C

CITY OF BALTIMORE: (No.

Fort McHenry, Md.

ST. 24

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Charles Norbert Bajart, 1st Lt. 58th Inf.

(Residence in Baltimore)

Lincoln Park, Yonkers, N.Y.

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

33

yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Soldier in

(b) General nature of industry, business, or establishment in which employed (or employer).

U.S. Army

9-BIRTHPLACE,

(State or Country),

N.Y.

10-NAME OF

Charles M. Bojart,

FATHER Lincoln Park, Yonkers, N.Y.

11-BIRTHPLACE

OF FATHER

(State or Country),

Unknown

12-MAIDEN NAME

OF MOTHER

Unknown

13-BIRTHPLACE

OF MOTHER

(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAY 4 - 1920

Filed

191

ROBERT B. KRAUTH

Burial Place Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 2, 1920

(Month)

(Day)

191

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 17, 1920

to May 2, 1920

191

that I saw him alive on May 2, 1920

and that death occurred, on the date stated above, at 9:10 p.m.

The CAUSE OF DEATH* was as follows:

(1) Tuberculosis pulmonary. (2) Carcinoma, Sigmoid flexure of the colon.

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Thomas J. Leary, Major, Medical Corps
May 3, 1920 (Address) Ft. McHenry, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL,

Yonkers N.Y.

DATE OF BURIAL,

May 4, 1920

20-UNDERTAKER

Max Leinson

ADDRESS 1127 E

Baltimore St

D42836

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D42836
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1053 W Lexington St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1053 W Lexington St.; 24 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

F

4-COLOR OR RACE,

C5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

April 30, 1884
(Month) (Day) (Year)

7-AGE,

34If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Domestic
(b) General nature of industry, business, or establishment in which employed (or employer). 8709-BIRTHPLACE,
(State or Country),Howard Co.

10-NAME OF FATHER,

James Waters11-BIRTHPLACE OF FATHER
(State or Country),Howard Co.

12-MAIDEN NAME OF MOTHER

Mellie Queen13-BIRTHPLACE OF MOTHER
(State or Country),Howard Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Sam Waters

(Address),

1029 Sarah Ann

15-

MAY 4 - 1920

Filed

191

ROBERT H. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 30 19120, to April 30 19120,that I saw h..... alive on April 30 19120,and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows: •

Cerebral Hemorrhage

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)Pulmonary Edema

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

May 1, 19120 (Address) 939 W Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn

DATE OF BURIAL,

April 4, 1920

20-UNDERTAKER

Brown & IrelandADDRESS 114 W.

140547
D42837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D42837

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Jopna Hopkins Hosp* ST. *26* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Philip Smith

(a) RESIDENCE. NO.

1811-8th St. Highlandtown WARD. *12th*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Eliz. Smith*

6 DATE OF BIRTH (month, day, and year)

Sept. 3-8 93

7 AGE

26

Years

7 Months*19* DaysIf LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Brakeman *073*

(b) General nature of industry, business, or establishment in which employed (or employer)

Penna R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Philip Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Erlyn Bramble

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant
(Address)*Hospital Record
J. H. H.*

15

FRI *MAY 4* 1920*ROBERT B. KAUFER*

Burial Permit No.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 2* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

April 29, 19*20*, to *May 2*, 19*20*,that I last saw him alive on *May 2*, 19*20*,and that death occurred, on the date stated above, at *10:10* P. M.

The CAUSE OF DEATH* was as follows:

*Chronic nephritis
uremia*(duration) *1* yrs. *4* mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?*?*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *J. Schumacher*, M. D.19 (Address) *J. Schumacher Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Balto Cem.

DATE OF BURIAL

May 6 19*20*

20 UNDERTAKER

Philip Henwig

ADDRESS

*2016
Oleum*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42838

D42838

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Winona Apt 5* ST. *11* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *Winona Apt 5* St. *60* yrs. *?* mos. *?* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*

6-DATE OF BIRTH,

*November**25**1836*

7-AGE,

83 yrs. *5* mos. *7* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Associated with American Agricultural Chemical Co.*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Louisville - Kentucky

PARENTS.

10-NAME OF FATHER,

Albert G. Griffith

11-BIRTHPLACE OF FATHER (State or Country),

Michaelville - Md

12-MAIDEN NAME OF MOTHER

Rebecca McCaslin

13-BIRTHPLACE OF MOTHER (State or Country),

Manassas

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs Ellen G. Clark (Daughter)*(Address) *Ellicott City - Md.*

15-

Filed

MAY 4 - 1920

191

ROBERT E. KRAUTER

Burial Permitted

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*May**2**1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Jan**1920*to *May 2**1920*that I saw him alive on *May 1* 1920,and that death occurred, on the date stated above, at *9:45 a.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Right Breast(Duration) *3* yrs. *?* mos. *?* ds.

CONTRIBUTORY (Secondary)

(Duration) *?* yrs. *?* mos. *?* ds.(Signed) *Wm. G. Allen* M. D.*May 3, 1920* (Address) *3501 Garrison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *?* yrs. *?* mos. *?* ds. In the *?* State *?* yrs. *?* mos. *?* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

*Druid Ridge Cemetery*20-UNDERTAKER
STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

DATE OF BURIAL

May 4, 1920

ADDRESS

108 W. NORTH AVE.

D42839

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42839

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2415 St Paul* ST. *12* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give the NAME instead of street and number.)

2-FULL NAME

Anna Maria Poial Leopold

(a) RESIDENCE. No.

*2415 St Paul*ST. *12*WARD. *(Resident)*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *55* yrs. *?* mos. *?* ds. How long in U. S., if of foreign birth? *83* yrs. *2* mos. *12* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Lewis Leopold

6 DATE OF BIRTH (month, day, and year)

Feb-21-1837

7 AGE

83

Years

Months

Days

If LESS than
1 day, hrs.
or min.*2**12*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Harrisonburg Virginia

10 NAME OF FATHER

Peter Brick

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Harrisonburg Virginia

12 MAIDEN NAME OF MOTHER

Fannie Sterling

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Massachusetts

14

Informant

(Address)

*Miss Rose Leopold (daughter)
2415 St Paul St*

15

Filed

*MAY 4 - 1920**ROBERT E. LEAUTER*

Registrar

Burial Permit *01013*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*5/3*19 *20*

17

I HEREBY CERTIFY, That I attended deceased from *2/30* 19 *20*, to *5/31* 19 *20*, that I last saw her alive on *5/3* 19 *20*, and that death occurred, on the date stated above, at *9:30 P. M.*

The CAUSE OF DEATH* was as follows:

*Arterio Sclerosis and
Bright's disease*(duration) *5* yrs. *1* mos. *1* ds.

CONTRIBUTORY (Secondary)

Age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*usual
J. Stanley Gorman, M. D.
2900 St Paul St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Harrisonburg-Rockingham Co Va**May 1920*

20 UNDERTAKER

ADDRESS

*Newton Mowen Co (H. H. Mowen Successor)**108 1/2 North Ave*

See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42840

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1440 R. Main St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1440 R. Main St. 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

(Address),

15-

Filed

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from 1912, to 1912, that I saw her alive on 1912 and that death occurred, on the date stated above, at 8:50 P.M. The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

May 3, 1912 (Address) Mrs. Mary Wright

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE

20-UNDERTAKER

ADDRESS

JAMES H. DENNIS

1303 PRESTMAN ST.

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42841

D42841

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1436 Muncie Alley ST. 3

WARD)

2-FULL NAME

Albert Jones

(Residence in Baltimore: No. 1436 Muncie Alley

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1S.)

11 St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Caloney

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

Married

6-DATE OF BIRTH,

12/21/1900 (Month) (Day) (Year)

7-AGE,

34 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

Saloon 070

9-BIRTHPLACE, (State or Country),

Living in Baltimore 11 years

10-NAME OF FATHER,

Deane Jones

11-BIRTHPLACE OF FATHER (State or Country),

Florida

12-MAIDEN NAME OF MOTHER

Kate

13-BIRTHPLACE OF MOTHER (State or Country),

Florida

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Albert Jones

(Address)

1436 Muncie Alley

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 1, 1920 (Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Henry S. ... (Coroner) 5/5/20 (Address) 1610 E. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Salisbury

DATE OF BURIAL,

May 4, 1920

20-UNDERTAKER

Mrs. J. A. Elliott

ADDRESS

1735

MAY 4 - 1920

191.

ROBERT H. ... Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42842

CERTIFICATE OF DEATH

35 D42842

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1002 Morton St. ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lee Augusta Osman

(Residence in Baltimore: No. 1002 Morton St. Sr. 8 yrs. 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (Write the word)

6-DATE OF BIRTH Sept 1, 1911 (Month) (Day) (Year)

7-AGE 8 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore Md

10-NAME OF FATHER Agoston Osman

11-BIRTHPLACE OF FATHER (State or country) known

12-MATERN NAME Carrie V. Osman

13-BIRTHPLACE OF MOTHER (State or country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carrie V. Osman

(Address) 1002 Morton St

15. MAY 4 - 1920 ROBERT H. TRAVER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May, 2nd, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 14, 1920, to May 2nd, 1920

that I saw her alive on May 2nd, 1920

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

General tuberculosis, (Abdominal symptoms most prominent)
(Duration) yrs. mos. ds.

Contributory Extreme marasmus
(SECONDARY) (Duration) yrs. mos. ds.

(Signed) John J. Jay M. D.
May 8th, 1920 (Address) 1028 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Laural Penn DATE OF BURIAL May 4th, 1920

20-UNDERTAKER Daniel E. Ertu ADDRESS 916 Ba ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42843

D42843

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *210 n Poppleton* ST.; *18* WARD)2-FULL NAME *William Spruill*(Residence in Baltimore: No. *210 n Poppleton* St.; yrs., mos., ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

M

4-COLOR OR RACE

*C*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Jan 24, 1920
(Month) (Day) (Year)

7-AGE,

2 yrs. 9 mos. 9 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Na

10-NAME OF FATHER,

Arvin Spruill

11-BIRTHPLACE OF FATHER (State or Country),

N.C.

12-MAIDEN NAME OF MOTHER

Josephine Anderson

13-BIRTHPLACE OF MOTHER (State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Arvin Spruill*(Address) *210 n Poppleton*

15-

Filed

MAY 4 - 1920

ROBERT B. KRAUTER

BIRTH PLACE REGISTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 3, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *April 15, 1920*, to *May 3, 1920*, that I saw him alive on *May 3, 1920*, and that death occurred, on the date stated above, at *4:45 P.M.*

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion
(Duration) yrs. mos. *30* ds.

CONTRIBUTORY (Secondary)

(Signed) *J. M. Card* yrs. mos. ds.*313*, 1920 (Address) *200 n Poppleton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Pigmyia

19-PLACE OF BURIAL OR REMOVAL

St. Ambrose

DATE OF BURIAL,

May 7, 1920

20-UNDERTAKER

Chas. Brown

ADDRESS

108 n Maryland

D42844

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42844

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1426 Drund Hill Ave ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Holmes(a) RESIDENCE, No. 1426 Drund Hill Ave ST. 14 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant6 DATE OF BIRTH (month, day, and year) Aug 17, 19177 AGE Years 2 Months 8 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md. (State or country)10 NAME OF FATHER Charles Hall11 BIRTHPLACE OF FATHER (city or town) Md (State or country)12 MAIDEN NAME OF MOTHER Laura Holmes13 BIRTHPLACE OF MOTHER (city or town) South Carolina (State or country)14 Informant Laura Holmes (Address) 1426 Drund Hill Ave15 MAY 4 - 1920

ROBERT A. LINDSEY

Porter-Pearl Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 1, 1920, to May 3, 1920,that I last saw him alive on May 3, 1920,and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No(Signed) E. William Fry M. D.5/4, 1920 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Auburn May 4, 1920

20 UNDERTAKER ADDRESS

Geo. H. Holland 1631 UnionHill

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42845

D42845

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 Columbia ST.: 21 WARD)2-FULL NAME Grace Schmidt(a) RESIDENCE. No. 1409 Columbia ST.,

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND
(or) WIFE ofWm Schmidt

6 DATE OF BIRTH (month, day, and year)

May 4, 1899

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.21.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore

10 NAME OF FATHER

Robert. Inverett.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Elle Pennington

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

14

Informant

(Address)

Wm Schmidt1409 Columbia

15

Filed

MAY 4 - 1920ROBERT H. KRAUTER
RegistrarEdith Smith

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 2 1920

17

I HEREBY CERTIFY, That I attended deceased from

Nov 1, 1917, to May 2, 1920.

that I last saw him alive on

April 30, 1920.

and that death occurred, on the date stated above, at

7:30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Harry Boyd

M. D.

(Address)

602 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London ParkMay 6 1920

20 UNDERTAKER

ADDRESS

Wm Cook & Co

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42846

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D42846

1 PLACE OF DEATH

CITY OF BALTIMORE (No. *265 East St.*)

ST. *5* WARD)

REGISTERED No. C *91* ✓

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME *Minnie Siegel*

(Residence in Baltimore: No. *265 East St.*)

St.: yrs. *2* mos. *17* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Single* (Write the word)

6 DATE OF BIRTH *February 17, 1920* (Month) (Day) (Year)

7 AGE *2* yrs. *17* mos. *17* ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) *Domestic*

9 BIRTHPLACE (State or country) *Balt Md*

10 NAME OF FATHER *Morris Siegel*

11 BIRTHPLACE OF FATHER (State or country) *Russia*

12 MAIDEN NAME OF MOTHER *Jennie Guisberg*

13 BIRTHPLACE OF MOTHER (State or country) *Russia*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J Lewis*

(Address) *1441 E. Balt St*

15

Filed

MAY 4 - 1920

191

ROBERT B. TRAUTER

Barial Permit Olorb

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *May 4, 1920* (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *May 1, 1920* to *May 4, 1920* that I saw her alive on *May 3, 1920* and that death occurred, on the date stated above, at *9:20* m. The CAUSE OF DEATH* was as follows: *Pneumonia*

Contributory (SECONDARY) *Pneumonia* (Duration) yrs. *4* mos. *17* ds.

(Signed) *E. C. P. P. P.* M. D. *May 4, 1920* (Address) *1441 E. Balt St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted. If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Hebrew Mt Carmel*

DATE OF BURIAL

5 4, 1920

20 UNDERTAKER

Jack Lewis

ADDRESS

1441 E. Balt St

Jorney
HEALTH DEPARTMENT—CITY OF BALTIMORE

D42847

CERTIFICATE OF DEATH.

108 D42847
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Balto. Gen. Hospital* ST. *23* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *808 Light* St.: *Life* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Single*

6-DATE OF BIRTH,

Unknown, 1
(Month) (Day) (Year)

7-AGE,

73 +

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Merchant*9-BIRTHPLACE,
(State or Country),*Baltimore, Md.*

PARENTS.

10-NAME OF FATHER,

*Garson Torney*11-BIRTHPLACE OF FATHER,
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER,
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Albert A. Torney Sr.

(Address)

*2413 Hillman Ave.*15
MAY 4 - 1920

Filed....., 191.....

ROBERT H. KRAUTER

Burial Permitted

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May, *2*, *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

5/2/20 1920, to *5/2/20* 1920,that I saw him alive on *5/2/20* 1920,and that death occurred, on the date stated above, at *11:30 P* m.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendix

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY

(Secondary)

Peritonitis
Chronic interstitial nephritis

(Duration).....yrs.....mos.....ds.

(Signed).....*Wetterbar Fork*.....M. D.*5/3/20*, 1920 (Address) *1213 Light St. Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

LOUDON PARK

DATE OF BURIAL,

MAY 5 - 1920

20-UNDERTAKER

JOHN F. DENNY

ADDRESS

715 LIGHT ST.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42848

D42848

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hosp.* ST.: *4* WARD)2-FULL NAME *Mr. Ed Smith*(a) RESIDENCE. No. *640 W. Lombard* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Married*6a If married, widowed, or divorced *HUSBAND of* (or) WIFE of *William Smith*6 DATE OF BIRTH (month, day, and year) *9/15/1863*

7 AGE

Years *56*Months *8*Days *17*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *037*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Chic.*10 NAME OF FATHER *Wm. Stewart*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Mame*12 MAIDEN NAME OF MOTHER *Johna Barney*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *N. Y.*

14

Informant *Wm D Smith*(Address) *640 W Lombard St*

15

Filed *MAY 4 - 1920*

ROBERT E. KAUFMAN

BRIAN KAUFMAN

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/2* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from *4/26* 19*20* to *5/2* 19*20*.that I last saw him alive on *5/2* 19*20*.and that death occurred, on the date stated above, at *5:45* a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) *7* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *h* Date ofWas there an autopsy? *h*

What test confirmed diagnosis?

(Signed) *Wm O. Ridgely* M. D.192 (Address) *Mary Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**May 4 1920*

20 UNDERTAKER

ADDRESS

Wm J. Fields 1200 W Lombard

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42849

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 235 S. Madera

ST.; 1 WARD)

2-FULL NAME

Josephine Schenckhoff

(a) RESIDENCE. NO.

235 S. Madera

ST.; 1 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.: How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Late Chas Schenckhoff

6 DATE OF BIRTH (month, day, and year)

1870

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

50 years

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Housework

(b) General nature of industry,
business, or establishment in
which employed (or employer)

At Home

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

John Rubenstein

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Germany

14

Informant
(Address)John Schenckhoff
235 S. Madera

15

MAY 4 - 1920

Burial Place

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 2 1920

17

I HEREBY CERTIFY, That I attended deceased from

January 12, 1920, to May 2, 1920

that I last saw him alive on May 1, 1920

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis and
Valvular Cardiac Disease
(initial)

(duration) yrs. 3 mos. 21 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Heart sounds - X-ray

(Signed) W. E. Burns, M. D.

, 19 (Address) 22185 Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer Cem.

DATE OF BURIAL

May 5 1920

20 UNDERTAKER

Lilly & Zeiler

ADDRESS

403 S. Wolfe

is very important. See instructions on back of certificate.

D42850

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

D42850

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Sydenham Hospital*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *229 S. Wolfe*)

Str.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *male* 4-COLOR OR RACE *white* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *single* (Write the word)

6-DATE OF BIRTH *Sept. 16, 1919* (Month) (Day) (Year)

7-AGE *7* yrs. *18* mos. *18* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Home job

9-BIRTHPLACE (State or country)

Baltimore city

10-NAME OF FATHER

Walter S. Drega.

PARENTS

11-BIRTHPLACE OF FATHER (State or country)

Austria.

12-MAIDEN NAME OF MOTHER

Katharine Wjtk

13-BIRTHPLACE OF MOTHER (State or country)

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter S. Drega.

(Address)

229 S. Wolfe St.

15-

MAY 4 - 1920

ROBERT E. KRAUTER

Filed

191

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 4, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 3, 1920, to May 4, 1920

that I saw him alive on *May 4, 1920*

and that death occurred, on the date stated above, at *6:20 a.m.*

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(Duration) yrs. mos. ds. *2-3*

Contributory (SECONDARY)

Brachopneumonia

(Duration) yrs. mos. ds. *2-3*

(Signed)

May 4, 1920

(Address) *Sydenham Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. *1* In the State yrs. mos. ds.

Where was disease contracted, If not at place of death? *at home*

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Holy Rosary Am.

DATE OF BURIAL

May 4, 1920

20-UNDERTAKER

Lilly & Zula

ADDRESS

403 S. Wolfe St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42851

CERTIFICATE OF DEATH.

108 D42851
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: 5 yrs., 3 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Single

6-DATE OF BIRTH,

Jan 11, 1915
(Month) (Day) (Year)

7-AGE,

5 yrs., 3 mos. 2 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Maryland

10-NAME OF FATHER

Frank M. Echle

11-BIRTHPLACE OF FATHER
(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Corinne Canabough

13-BIRTHPLACE OF MOTHER
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Frank M. Echle
2134 W. Fayette St.

15-

MAY 4 1920

Robert P. Harrison,

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 2, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

572/20th 191, to 572/20th 191,that I saw him alive on 572/20th 191,

and that death occurred, on the date stated above, at 7:00 p.m.

The CAUSE OF DEATH* was as follows:

acute appendicitis
peritonitis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....J. J. J. M. D.

572/20th, 191... (Address) Bon Secours Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Cem 5/6, 1920

20-UNDERTAKER

ADDRESS

George J. J. J. J. J.

D42852

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 N. Rose ST.: 7 WARD)2-FULL NAME Charles Carmel Richardson(a) RESIDENCE. NO. 502 N. Rose ST.: 7 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yr. mos. 0 ds. How long in U. S., if of foreign birth? yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Dec 3, 19057 AGE Years 14 Months 5 Days 0 If LESS than 1 day, hrs. 0 or min. 0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)10 NAME OF FATHER Charles Richardson11 BIRTHPLACE OF FATHER (city or town) Wash D.C.
(State or country)12 MAIDEN NAME OF MOTHER Marion Pratt13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)14 Informant Marion Richardson
(Address) 502 N. Rose15 Filed 1920 19 ROBERT F. HARRISON,
Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 19 2017 I HEREBY CERTIFY, That I attended deceased from April 1, 19 20 to May 3, 19 20.that I last saw him alive on May 3, 19 20and that death occurred, on the date stated above, at 9 P.M. m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis(duration) yrs. 3 mos. 4 ds.CONTRIBUTORY
(Secondary)(duration) yrs. 1 mos. 0 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date of —Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Owen, M. D., 19 (Address) 14 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cato LawnMay 6 19 20

20 UNDERTAKER

ADDRESS

Wm. CookN.Y. & Co.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42853

D42853

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *5212 Main*)ST. *28* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) ~~WIFE of~~*Eleanora Harman*

6 DATE OF BIRTH (month, day, and year)

4-10-1845

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*75**24*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Print Manufacturer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Maryland*

10 NAME OF FATHER

*David Harman*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Maryland*

12 MAIDEN NAME OF MOTHER

*Susanna Knipp*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Maryland*

14

Informant
(Address)*Eleanora Harman*
5212 Main St. City

15

Filed, 19

Registrar

David Peritt Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-4-1920*

17

I HEREBY CERTIFY, That I attended deceased from
Apr. 30, 19*20*, to *May 3*, 19*20*,
that I last saw him alive on *May 2*, 19*20*,
and that death occurred, on the date stated above, at *6:50 a. m.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(duration) yrs. mos. *5* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date of *-*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Robert F. Funderburk*, M. D., 19 (Address) *Main Street*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**May 6* 19*20*

20 UNDERTAKER

ADDRESS

*Geo W Little**5314 Fremont Ave*

FROM IS VERY IMPORTANT. See instructions on back of certificates.

EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. See instructions on back of certificates.

D42854

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42854

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 25th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Warrant Snyder

(a) RESIDENCE. NO.

108 Cherry St. Curtis Bay Md.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

Life

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

X

6 DATE OF BIRTH (month, day, and year)

Oct - 1 - 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7 mo.2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Charles Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mattie Christine

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

John B. Records

15

Filed

19

1920Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 19 20

17

I HEREBY CERTIFY, That I attended deceased from

April 26 19 20, to May 3rd 19 20,that I last saw her alive on May 3rd 19 20,and that death occurred, on the date stated above, at 9:45 P. M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 7 ds.18 Where was disease contracted if not at place of death? Patent & HomeDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) des. tapp M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill CemMay 5 19 20

20 UNDERTAKER

ADDRESS

M. J. Flynn1422 Light

D42855

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42855

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. (yrs., 38) mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.)

I find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Induced by some person - ...
Opium acid.
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

May 4, 1920 (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

MAY 4 - 1920

191

Burial Permit Clerk

London Park
Geo. L. Schwab & Co. 2101 Frederick Ave.

D42856

HEALTH DEPARTMENT-CITY OF BALTIMORE

D42856

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

St. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St. 1 yrs. - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

female

4-COLOR OR RACE

white

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

married

6-DATE OF BIRTH

June 6, 1890
(Month) (Day) (Year)

7-AGE

29 yrs. 10 mos. 26 ds.

If LESS than
1 day, ---- hrs.
or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Home duties

9-BIRTHPLACE
(State or country)

Balt. Co. Md

10-NAME OF FATHER

John Edler

11 BIRTHPLACE OF FATHER
(State or country)

Balt. Co. Md

12 MAIDEN NAME OF MOTHER

Ida Arnold

13 BIRTHPLACE OF MOTHER
(State or country)

Balt. Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. F. Foutz

(Address)

Annapolis, Md

15

Robert P. Harrison,

Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 3, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 29, 1920, to May 3, 1920
that I saw her alive on May 2, 1920

and that death occurred, on the date stated above, at 1:30 AM

The CAUSE OF DEATH* was as follows:

Phtthisis Pulmonalis

(Duration) 6 yrs. - mos. - ds

Contributory
(SECONDARY)

(Duration) 6 yrs. - mos. - ds

(Signed) Geo. L. Schwalb, M. D.

May 4, 1920 (Address) Morrell Park, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

May 5, 1920

20-UNDERTAKER

Geo. L. Schwalb & Bro. 210 Frederick Ave

MAY 4 - 1920

D42857

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42857

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 238 S. Washington St.; 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 238 S. Washington St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

May 4, 1920
(Month) (Day) (Year)

7-AGE,

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. no
(b) General nature of industry, business, or establishment in which employed (or employer). ooo9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Baltimore12-MAIDEN NAME OF MOTHER Mary Nosowicz13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), John Hepchen(Address), 238 S. Washington

15-

Filed May 4 1920 Robert P. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 4, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 4 1920, to May 4 1920,that I saw her alive on May 4 1920, and that death occurred, on the date stated above, at 4:15 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) W. H. M. D.
May 4, 1920 (Address) St. Ann's Church

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Ann's ChurchMay 5, 1920

20-UNDERTAKER

ADDRESS

M. F. Sadowski, 705 S. Ann St.

D42858

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42858

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 126 Kennedy St.)

WARD)

2-FULL NAME

Susan T Walsh,

(Residence in Baltimore: No. 126 Kennedy St.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 45 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH,

June 24, 1874
(Month) (Day) (Year)

7-AGE,

45

yrs. 10 mos. 8 da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,
(State or Country),

Balto. Ind

10-NAME OF FATHER,

James P. Flaherty

11-BIRTHPLACE OF FATHER
(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Mary G. Lynch

13-BIRTHPLACE OF MOTHER
(State or Country),

Balto. Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John J. Walsh

(Address)

126 Kennedy St.

15-

Robert P. Harrison,

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 2, 1940
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereof and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Sullivan M. D.

(Coroner)

522nd (Address) 18th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Patrick's Cemetery

5/5/1940

20-UNDERTAKER

ADDRESS 3000

J. H. Moran

8 Baltolt

AY 4-1920 Burial permit clerk, Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42859

D42859

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2131 Mc Colloch ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Carlin

(a) RESIDENCE. NO.

2131 Mc Colloch

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

65 yrs. 1 mos. 16 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofFrank Carlin

6 DATE OF BIRTH (month, day, and year)

March 17 1855

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.65116

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore Md.

10 NAME OF FATHER

Daniel Dean

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto Md

14

Informant
(Address)The Grand Carlin
2131 Mc Colloch St

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 3 1920

17

I HEREBY CERTIFY, That I attended deceased from

May, 1918, to May 3, 1920.that I last saw him alive on May 3, 1920.and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(duration) 2 yrs. mos. ds.CONTRIBUTORY
(Secondary)Spur Anemia(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) A. C. Pole, M. D., 19 (Address) 2034 Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral CewMay 6 1920

20 UNDERTAKER

ADDRESS 1944Narry W. Ehlert

This is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42860

CERTIFICATE OF DEATH.

D42860

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 747 W. Cross ST. 21 WARD)2-FULL NAME Martha L. Bailey(a) RESIDENCE, No. 747 W. Cross ST. 21 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? 78 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofCharles W. Bailey6 DATE OF BIRTH (month, day, and year) May 2 18427 AGE Years 78 Months 0 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER Jacob Wilson11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore12 MAIDEN NAME OF MOTHER Louisa Clark13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore14 Informant Lusie E. Wilson
(Address) 747 W. Cross15 Robert T. Harrison

1920

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-3 1920

17

I HEREBY CERTIFY, That I attended deceased from April 10, 1920, to May 3, 1920.that I last saw her alive on May 3, 1920.and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH* was as follows:

Fracture of hip
Carcinoma of uterus(duration) yrs. mos. 23 ds.CONTRIBUTORY (Secondary) Pneumonia(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death? noDid an operation precede death? no Date of (over)Was there an autopsy? noWhat test confirmed diagnosis? Examination(Signed) Jas HODGKINS, M. D.1910 (Address) 107 E. Mt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western CemeteryMay 6 1920

20 UNDERTAKER

ADDRESS

Jos. J. J. J. J.2178 P. St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42861

CERTIFICATE OF DEATH.

D42861

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *27* WARD)

REGISTERED NO. C

2-FULL NAME *Anna Louise Mitchell*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *301 Gramore Road, Hamilton, Md.* St.: *Baltimore* yrs. *5* mos. *19* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

May *25*, *1859*
(Month) (Day) (Year)

7-AGE,

60 yrs. *11* mos. *7* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Trained nurse*
(b) General nature of industry, business, or establishment in which employed (or employer) *048*9-BIRTHPLACE,
(State or Country),*Pennsylvania*

10-NAME OF FATHER,

Charles W. Mitchell

11-BIRTHPLACE OF FATHER

(State or Country), *Pennsylvania*

12-MAIDEN NAME OF MOTHER

Catherine Jackson

13-BIRTHPLACE OF MOTHER

(State or Country), *Pennsylvania*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Records, Johns Hopkins Hospital*(Address) *Baltimore, Md.*

15-

Robert F. Harrison,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May *4*, *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Feb. 14 *1920*, to *May 4* *1920*,that I saw her alive on *May 4* *1920*,and that death occurred, on the date stated above, at *3.15 p.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of the large intestine.(Duration) *10* yrs. *10* mos. *10* ds.CONTRIBUTORY *Intestinal Obstruction*
(Secondary)(Duration) *3* yrs. *3* mos. *3* ds.(Signed) *Ruth E. Fairbank* M. D.*May 4*, *1920* (Address) *Johns Hopkins Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. *2* mos. *20* ds. in the State yrs. *5* mos. *19* ds.Where was disease contracted, if not at place of death? *Pennsylvania* ①Former or usual residence *Baltimore, Md.* ②

19-PLACE OF BURIAL OR REMOVAL,

Louder Park

DATE OF BURIAL,

May 5, *1920*

20-UNDERTAKER

Joseph Abrams

ADDRESS

*221 N. Broadway*MAY 4 - 1920 Burial Permit Clerk
Registrar.

D42862

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42862

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. ST. 17* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Jonathan Merrifield

(a) RESIDENCE. NO.

Catappa N. Va ST.

WARD.

12th W. Va

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Widowed

6 DATE OF BIRTH (month, day, and year)

Nov 16 - 1856

7 AGE

64

Years

5

Months

18

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

West Virginia

10 NAME OF FATHER

Eugene Merrifield

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N. Va.

12 MAIDEN NAME OF MOTHER

M. Tolliff

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N. Va.

14

Informant (Address)

Robert P. Harrison

15

Filed

1920

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 4 1920

17

I HEREBY CERTIFY, That I attended deceased from

*April 5, 1920, to May 4, 1920.*that I last saw him alive on *May 4, 1920.*and that death occurred, on the date stated above, at *2:35 p.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration)

yrs.

3

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

Yes

Date of

April 29, 1920

Was there an autopsy?

Yes

What test confirmed diagnosis?

Autopsy.

(Signed)

Dr. H. H. Hollman, M. D.

, 19

(Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Farmington N. Va.**May 5 1920*

20 UNDERTAKER

ADDRESS

*Joseph Ahrens**221 N. Broadway*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42863

D42863

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 200 S 7thST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Adeline Trotto

(a) RESIDENCE. NO.

200 S 7th

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 1 mos. 3 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar 30 - 1907

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1313

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at school

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

BaltoMd

10 NAME OF FATHER

John Trotto

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Carrie Florenz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

John Trotto
200 S 7th St

15

MAY 5 - 1920

ROBERT B. ELLIOTT

Registrar

Social Pathol Unit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 3 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 15, 1920 to May 3, 1920that I last saw her alive on May 2, 1920and that death occurred, on the date stated above, at 6:20 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

CONTRIBUTORY (Secondary)

Typhoid fever

18 Where was disease contracted

at place of death

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

Signed Maxwell L. Mayer M. D.3, 1920 (Address) 3115 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL

DATE OF BURIAL

St. StanislausMay 5 1920

20 UNDERTAKER

ADDRESS

John Delia200 S 7th St

D42864

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42864

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 S Bouldin ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

August A) Keller

(a) RESIDENCE. NO.

202 S Bouldin ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofMary Morgereth

6 DATE OF BIRTH (month, day, and year)

Apr 1 - 1885

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.3512

8 OCCUPATION OF DECEASED

R R Conductor

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

P. R. R.

9 BIRTHPLACE (city or town) (State or country)

Balt Md

10 NAME OF FATHER

Aug Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt Md

12 MAIDEN NAME OF MOTHER

Clea Otten

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt Md

11

Informant
(Address)Mary Keller
202 S Bouldin

15

MAY 5 - 1920ROBERT H. KRAUTER

Registrar

DEPT. HEALTH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 3 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 1 1920 to May 3 1920that I last saw him alive on May 3 1920and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute
Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy? no

What test confirmed diagnosis?

Clinical Sympt(Signed) J. J. Hermann M. D.(Address) 7919 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn Cem

DATE OF BURIAL

May 6 1920

20 UNDERTAKER

J. Hermann

ADDRESS

2008 Calver

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *905 Morris* ST.; *11* WARD)2-FULL NAME *Samuel Jones*(Residence in Baltimore: No. *905 Morris* St.; *1* yrs., *1* mos., *1* ds.)REGISTERED NO. *C*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*4-COLOR OR RACE, *Colored*5-SINGLE *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *1878*, *1*.....
(Month) (Day) (Year)7-AGE, *42*
.....yrs.....mos.....ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Balt., Co.,*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *MD,*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *MD,*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Samuel Jones*(Address) *905 Morris St.*

15-

Filed.....

*MAY 5 - 1920**ROBERT E. KEAUTER**BORIAL PARLOR*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 3d*, *1920*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *April 11 1920* to *May 3d 1920*, that I saw him alive on *May 1st 1920*, and that death occurred, on the date stated above, at *2 A* m. The CAUSE OF DEATH* was as follows:*Senile Dementia*

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *A. E. Jones* M. D.*43*....., 191*2*. (Address) *724 Mod. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *St. Paulus Church*DATE OF BURIAL, *5/5/20*, 191*2*...20-UNDERTAKER *Samuel Easton*ADDRESS *916 Penna St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42866

CERTIFICATE OF DEATH.

REGISTERED NO. C

D42866

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square Hotel* ST. *18* WARD)

2-FULL NAME

(Residence in Baltimore: No. *2929 Riggs Ave* St. *31* yrs. *1* mos. *19* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

M.

4-COLOR OR RACE

*W.*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.) *Married*

6-DATE OF BIRTH

March 15, 1889
(Month) (Day) (Year)

7-AGE

*31 yrs. 1 mos. 19 ds.*If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Salesman*(b) General nature of industry, business, or establishment in which employed (or employer). *Current & Son, Balto Md*9-BIRTHPLACE,
(State or Country)*Balto Md*

10-NAME OF FATHER

*Alfred Davis*11-BIRTHPLACE OF FATHER
(State or Country)*Balto Md*

12-MAIDEN NAME OF MOTHER

*unknown*13-BIRTHPLACE OF MOTHER
(State or Country)*unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Mabel E. Davis wife*(Address) *2929 Riggs Ave*

15-

Filed *MAY 5 - 1920*

ROBERT B. FRAUTER

BALTIMORE CITY CLERK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 4, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Apr 17, 1920, to May 4, 1920*that I saw him alive on *May 4, 1920*and that death occurred, on the date stated above, at *2:50 P.M.*

The CAUSE OF DEATH* was as follows:

Nephritis cystitis(Duration) *Septicemia* yrs. mos. ds.CONTRIBUTORY
(Secondary)(Duration) *Septicemia* yrs. mos. ds.(Signed) *Newton J. Park* M. D.*5/4, 1920* (Address) *Franklin Square Hotel*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death *17* yrs. *31* mos. *19* ds. In the State *31* yrs. *1* mos. *19* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *2929 Riggs Ave*

19-PLACE OF BURIAL OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

May 7, 1920

20-UNDERTAKER

George J. Smith

ADDRESS

1800 N. ...

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42867

CERTIFICATE OF DEATH.

D42867

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 McCall St.)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 1507 McCall St.)

ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAY 5 - 1920

ROBERT B. RAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

Feb 1st 1920, to May 3rd 1920,

that I saw him alive on May 3rd 1920,

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Malignant Carcinoma of Rectum glandular type (no operation) (Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yr. mos. ds.

(Signed) Geo H. Cairnes, M. D.

May 4th 1920 (Address) 21025 1st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Wind Ridge Cemetery

May 7, 1920

20-UNDERTAKER

ADDRESS

George Smith

Gayeth St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42868

CERTIFICATE OF DEATH.

28 D42868

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *504 N. Castle* ST.: *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Elizabeth P. Glaser*(a) RESIDENCE. NO. *504 N. Castle* ST. *7* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced.

HUSBAND of (or) WIFE of *John D. Glaser*6 DATE OF BIRTH (month, day, and year) *Sept 28, 1888*7 AGE Years *31* Months *7* Days *3* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *037*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*10 NAME OF FATHER *James Mallon*11 BIRTHPLACE OF FATHER (city or town) *Balto* (State or country) *Med.*12 MAIDEN NAME OF MOTHER *Mathilda Greut*13 BIRTHPLACE OF MOTHER (city or town) *Balto* (State or country) *Med.*

14

Informant *John D. Glaser* (Address) *504 N. Castle St.*15 Filed *MAY 5 - 1920*

ROBERT E. KRAUTER

Registrar

BRIAN P. M. O'NEILL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 1 1920*

17

I HEREBY CERTIFY, That I attended deceased from

May 15, 19*20*, to *May 1*, 19*20*, that I last saw her alive on *May 1*, 19*20*and that death occurred, on the date stated above, at *8:55 P.* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) *1* yrs. *1* mos. *1* ds.CONTRIBUTORY (Secondary) *Acute Edema of Lungs*(duration) *1* yrs. *1* mos. *1* ds.18 Where was disease contracted if not at place of death? *unknown*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *findings*(Signed) *F. Fred. Russell*, M. D.5-5, 1920 (Address) *800 N. Patterson St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *St Pauls Cem*DATE OF BURIAL *May 5 1920*20 UNDERTAKER *H. Sander Lous*ADDRESS *1700 Red St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42869

CERTIFICATE OF DEATH.

91 D42869

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3311 First Ave (Easton) WARD) 126

2-FULL NAME

Mary Long

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

3311 First Ave

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofFrank Long

6 DATE OF BIRTH (month, day, and year)

May 5th 1849

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.701129

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Germany

10 NAME OF FATHER

Michael Single

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Not known

14

Informant
(Address)Frank Long
3311 First Ave

15

MAY 5 - 1920ROBERT F. KRAUTERRegist. 01811
Death Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 4th 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 1st, 1920, to May 4th, 1920,that I last saw her alive on May 3rd, 1920,and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia(duration) yrs. mos. 3 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? none(Signed) D. W. Jones, M. D.5/5, 1920 (Address) 1013 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn Cem.

DATE OF BURIAL

May 7 1920

20 UNDERTAKER

He Sander Sons

ADDRESS

1710 West St

D42870

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42870

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2034 Orleans ST.; 6 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2034 Orleans St. St.; 50 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <u>Male</u>	4-COLOR OR RACE, <u>White</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <u>Married</u>
6-DATE OF BIRTH, <u>Sept</u> <u>19</u> , <u>1850</u> (Month) (Day) (Year)		
7-AGE, <u>69</u> yrs., <u>7</u> mos., <u> </u> ds. If LESS than 1 day,hrs. or....min.?		

8-OCCUPATION:
(a) Trade, profession, or particular kind of work... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country).Germany.

PARENTS.	10-NAME OF FATHER, <u>Frank M. Dietz</u>
	11-BIRTHPLACE OF FATHER (State or Country). <u>Germany.</u>
	12-MAIDEN NAME OF MOTHER <u>Magdalena Krug.</u>
	13-BIRTHPLACE OF MOTHER (State or Country). <u>Germany.</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie M. Dietz(Address) 2034 Orleans St.

15-

Filed

MAY 5 - 1920

ROBERT E. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 3, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Mar 5 1920, to May 3 1920,
that I saw him alive on May 2 1920,
and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial InfarctionCONTRIBUTORY
(Secondary)

(Duration) 2 yrs., 1 mos., 1 ds.
(Signed) E. C. Shade M. D.
143 W. 2nd St., 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer May 6, 1920

20-UNDERTAKER

ADDRESS

Frank A. Pink 915 N. Gay St.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42871
1-PLACE OF DEATHCITY OF BALTIMORE: (No. *Hebrew Hospital* ST. *5* WARD)2-FULL NAME *Mrs. Gussie Grod*(Residence in Baltimore: No. *123 N. High* St.; *20* yrs., *0* mos., *0* ds.)91 D42871
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and set out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Married

6-DATE OF BIRTH,

Unknown, *1* (Month) (Day) (Year)

7-AGE,

41

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country),

Austria

PARENTS.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Lewis*(Address) *1441 E. Balt St*

15-

Filed

MAY 5 - 1920

ROBERT H. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 30 1920, to *May 4 1920*,that I saw her alive on *May 14 1920*,and that death occurred, on the date stated above, at *4 p. m.*

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Charles S. Linn*5-4-1920. (Address) *Hebrew Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? *at home*Former or usual residence *123 St. High St*

19-PLACE OF BURIAL OR REMOVAL,

Hebrew Rosevale

DATE OF BURIAL,

5/5, 1920

20-UNDERTAKER

Jack Lewis

ADDRESS

1441 E. Balt St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42872
1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

79 D42872
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I attended deceased from

April 8 1920, to May 4 1920, that I saw her alive on May 4 1920, and that death occurred, on the date stated above, at 5:13 A.M.

The CAUSE OF DEATH* was as follows:

Sub-acute Endocarditis
Myocardial Insufficiency
Hypertension(Duration) ... yrs. ... mos. ... ds.
Contributory ... Uterine Cardiac Distention
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

May 4, 1920. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42873

CERTIFICATE OF DEATH.

79

D42873

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *836 W. Pratt*)ST.: *18* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Elizabeth Evans*(a) RESIDENCE. No. *836 W. Pratt*

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *35* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept 27 1852*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *67 7 6*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *000*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *MD*10 NAME OF FATHER *L B Evans*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *Sarah A Maxwell*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore*14 Informant *George E Rowley* (Address) *836 W. Pratt Street*15 Filed *MAY 5 - 1920* ROBERT H. RAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 3 1920*17 I HEREBY CERTIFY, That I attended deceased from *Mar 28*, 19*20*, to *May 3*, 19*20*, that I last saw him alive on *May 3*, 19*20*, and that death occurred, on the date stated above, at *1 P.* m.

The CAUSE OF DEATH* was as follows:

Heart of Arterio Sclerosis.(duration) *40 yrs.* yrs. mos. ds.CONTRIBUTORY (Secondary) *Coronary Arterio Sclerosis*(duration) *10 yrs.* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Bernard J. Terry*, M. D.*5/4*, 19*20* (Address) *710 W Lombard*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St Marys Ch. Hampden**May 5 1920*

20 UNDERTAKER

ADDRESS

*Joseph B Cook**1003 W. Balto St*

D42874

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2107 E. Chase* ST.; *8* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Scolastica Didomenicus

(a) RESIDENCE. NO.

2107 E. Chase ST.

WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., If of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar 8/19

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

3 1 26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Washington D.C.*

10 NAME OF FATHER

*Berarda Didomenicus*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Italy*

12 MAIDEN NAME OF MOTHER

*Fortunate*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Italy*

14

Informant
(Address)*Berarda Didomenicus
2107 E. Chase*

15

Filed
MAY 5 - 1920*LESTER R. LAOTER*
Registrar

Burial Permit Closed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 4 1920

17

I HEREBY CERTIFY, That I attended deceased from

*April 28 1920, to May 4 1920*that I last saw her alive on *May 4 1920*and that death occurred, on the date stated above, at *2:30 p.m.*

The CAUSE OF DEATH* was as follows:

Measles(duration) yrs. mos. *4* ds.CONTRIBUTORY
(Secondary)(duration) yrs. mos. *3* ds.18 Where was disease contracted
if not at place of death?*unknown*Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *F. F. Putschba* M. D.4. 1920 Address) *800 N. Patterson St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer**May 5 1920*

20 UNDERTAKER

ADDRESS

*Philip Herwig**2016
Arlens*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42875

CERTIFICATE OF DEATH.

120 D42875
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 Lewis

ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Joins

(Residence in Baltimore: No. 507 Lewis

St.: 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. C.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, 9/1/1910

(Month)

(Day)

(Year)

7-AGE, 40

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

house work 037

9-BIRTHPLACE, (State, or Country),

living Baltimore 2 years

10-NAME OF FATHER, Daniel Skinner

11-BIRTHPLACE OF FATHER (State or Country),

N.C.

12-MAIDEN NAME OF MOTHER, Hester Skinner

13-BIRTHPLACE OF MOTHER (State or Country),

N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. F. Gordon

(Address) 718 E. Fayette

15-

Filed MAY 5 - 1920

ROBERT B. KAUTER

Burial Park

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 2, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from April 20 1920, to April 27 1920,

that I saw her alive on April 27 1920,

and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Bright's disease

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) ... yrs. ... mos. ... ds.

(Signed) A. F. Gordon M. D.

May 3, 1920. (Address) 718 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Family in Edenboro NC

DATE OF BURIAL, May 3, 1920

20-UNDERTAKER, Mrs. R. A. Elliott

ADDRESS 1725

Fahland

D42876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 W PrestonST. 17

WARD)

REGISTERED No. C

2-FULL NAME

John Paul Storrs

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 510 W PrestonSt. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Caucasoid5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Single

6-DATE OF BIRTH.

April 231916

(Month)

(Day)

(Year)

7-AGE,

4

yrs.

mos.

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Child9-BIRTHPLACE,
(State or Country),Balto md.

PARENTS.

10-NAME OF FATHER,

Jerry Storrs11-BIRTHPLACE OF FATHER
(State or Country),Virginia

12-MAIDEN NAME OF MOTHER

Martha Jackson13-BIRTHPLACE OF MOTHER
(State or Country),Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jerry Storrs Father(Address) 510 W Preston St

MAY 5 - 1920

Filed..... 191

ROBERT B. KRAUTER

Burial Place (Regist.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May - 3d1910

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 28, 1920, to May 3, 1920,that I saw him alive on May 3d 1920,and that death occurred, on the date stated above, at 11:30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Gastric Intestinal
Distention, Indigestion,
Exhaustion (Duration) about 1 yrs. 1 mos. 1 ds.CONTRIBUTORY
(Secondary)about 2 months ago (Duration) about 2 yrs. 1 mos. 1 ds.(Signed) James M. D.May 4, 1920 (Address) 234 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

W. Auburn Cemetery

DATE OF BURIAL,

May 5, 1920

20-UNDERTAKER

Jos M Johnson

ADDRESS

1234 Ething St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42877

CERTIFICATE OF DEATH.

37 D42872
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1220 S. 1st ST.; 26 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1220 S. 1st St.)

St.; yrs., 2 mos. 22 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Single

6-DATE OF BIRTH,

Feb 11, 1920

(Month)

(Day)

(Year)

7-AGE,

2 yrs. 22 mos. 22 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country).

Baltimore Md

PARENTS.

10-NAME OF FATHER,

Frederick Deekelman

11-BIRTHPLACE OF FATHER

(State or Country).

Baltimore Md

12-MAIDEN NAME OF MOTHER

Munfred Feehley

13-BIRTHPLACE OF MOTHER

(State or Country).

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Frederick Deekelman

(Address)...

1220 S. 1st St.

15-

Filed

MAY 5 - 1920

ROBERT E. KRAUTER

101

BALTIMORE HEALTH DEPARTMENT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 3rd, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 30, 1920, to May 3, 1920.

that I saw her alive on May 3, 1920.

and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis
probably acute (hereditary?)

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

of Heart (Duration) yrs. mos. ds.

(Signed) Leo Krasnowsky, M. D.

May 4, 1920 (Address) 3030 Dorell

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn Cemetery

DATE OF BURIAL,

May 5, 1920

20-UNDERTAKER

Lilly & Zeller

ADDRESS

403 S. Wolfe St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42879

CERTIFICATE OF DEATH.

80 D42879

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *118 S. Stricker* ST.: *19* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Michael Murphy*(a) RESIDENCE. NO. *118 S. Stricker* ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *55* yrs. mos.ds. How long in U. S., if of foreign birth? *55* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

*Married*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *Elizabeth Broderick*6 DATE OF BIRTH (month, day, and year) *Unknown 1855*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

65

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

City policeman 061

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Baltimore City

9 BIRTHPLACE (city or town) (State or country)

*Ireland*10 NAME OF FATHER *John Murphy*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant *Miss Ely Murphy*
(Address) *118 S. Stricker St.*

15

Filed *19*

MAY 5 - 1920

ROBERT H. KRAUSE

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 3 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb. 1 1918, to May 3 1920,*that I last saw him alive on *May 3 1920*

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Angina pectoris(duration) *2* yrs. mos. ds.CONTRIBUTORY *Cardiac paralysis*
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Don't know*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *None*(Signed) *J. B. Round*, M. D.*54, 1920* (Address) *904 N. Charles St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral Cen**May 6 1920*

20 UNDERTAKER

ADDRESS

John J. Curran & Son 201 Hollins

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42880

CERTIFICATE OF DEATH.

28 D42880

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Rocke Park McHale ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sarah Sidney Brown

(a) RESIDENCE. NO.

Rocke Park McHale ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE White	5 Single, Married, Widowed, or Divorced (write the word) Married
5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Brown		
6 DATE OF BIRTH (month, day, and year) Feb 15 - 1872		
7 AGE 48	Years 2	Months 19
If LESS than 1 day, hrs. or min.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

John Archibald

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Endie's Park

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Md.

14

Informant
(Address)

Rocke Park McHale

15

Filed

MAY 5 - 1920

ROBERT A. LAUTER

Baltimore

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1920

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1920, to May 4, 1920, that I last saw him alive on May 4, 1920, and that death occurred, on the date stated above, at 11:40 a.m. The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

No, last year.

18 Where was disease contracted if not at place of death?

I don't know.

Did an operation precede death?

Date of

Was there an autopsy?

Yes.

What test confirmed diagnosis?

Clinical.

(Signed)

J. H. Clark, M. D.

347, 1920 (Address)

Arlington.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Home

March 6 1920

20 UNDERTAKER

H. C. Clark

ADDRESS

H. C. Clark

Gues

D42881

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42881

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur Bennett(a) RESIDENCE. No. 2831 O'Donnell St. ST. 1 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofHelen Bennett6 DATE OF BIRTH (month, day, and year) 18787 AGE Years Months Days If LESS than 1 day, hrs. or min.
42

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland10 NAME OF FATHER Adam Bennett11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)12 MAIDEN NAME OF MOTHER Sarah Downing13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)14 Informant Hospital Records
(Address) M.T.H.15 Filed MAY 5 1920 ROBERT I. KRAUTER
Registrar

Bottle Permit Class

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4th 192017 I HEREBY CERTIFY, That I attended deceased from April 20th, 1920, to May 4th, 1920,
that I last saw him alive on May 3rd, 1920,
and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus(duration) 1 yrs. 6 mos. ds.CONTRIBUTORY Pulmonary tuberculosis
(Secondary)(duration) 1 yrs. 6 (2) mos. ds.18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George R. Williams, M. D.5-4-20 Address Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Trinity CemeteryMay 7-1920

20 UNDERTAKER

ADDRESS

William Cook502 E. Pratt

D42882

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42882

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4411 Pimlico Ave. ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William H Walker(a) RESIDENCE. NO. 4411 Pimlico Ave. ST. 15 WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 10 - 1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

78924

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired 080

(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant Tailor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balts md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balts md.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balts md.

14

Informant (Address)

Mrs. Della M. Stauff 4411 Pimlico Ave.

15

MAY 5 - 1920

ROBERT B. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1920

17

I HEREBY CERTIFY, That I attended deceased from Apr. 30, 1920, to May 4, 1920, that I last saw him alive on May 4, 1920, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Heart Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. S. Schumacher

M. D.

19

(Address)

3101 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

GilemontMay 7 1920

20 UNDERTAKER

ADDRESS

Wm. Cook 502 E. North Ave

D42883

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42883

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1246 N. Broadway

ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward R. Hutchings

(a) RESIDENCE. NO. 1246 N. Broadway

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of Ida V. Hutchings

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
68				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penna. R. R.

9 BIRTHPLACE (city or town)

(State or country) N. Carolina

10 NAME OF FATHER W. D. Hutchings

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Julia McKee

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. Carolina

14

Informant

Ida V. Hutchings

(Address)

1246 N. Broadway

15

MAY 5 - 1920

ROBERT B. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1920

17

HEREBY CERTIFY, That I attended deceased from April 1, 1918, to May 3, 1920, that I last saw him alive on May 3, 1920, and that death occurred, on the date stated above, at 5:20 p. m.

The CAUSE OF DEATH* was as follows:

Bright Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination of urine

(Signed) R. B. Bagl M. D.

19 (Address) 709 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park Cemetery

May 6, 1920

20 UNDERTAKER

ADDRESS

Wm. C. Black, 927 N. Broadway

D42881

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42881

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1369 Reynolds* ST.; *24* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *1369 Reynolds* St.; *1* yrs., *1* mos., *14* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *F* 4-COLOR OR RACE, *W* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Child*
(Write the word.)
6-DATE OF BIRTH, *March 21*, 191*9*.
(Month) (Day) (Year)

7-AGE, *1* yrs., *1* mos., *14* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer). *ad*

9-BIRTHPLACE, (State or Country), *Baltimore*

PARENTS.
10-NAME OF FATHER, *James Kordonsky*
11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*
12-MAIDEN NAME OF MOTHER, *Rozalia Izdepsky*
13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James Kordonsky*(Address) *1369 Reynolds St.*

15-

Robert P. Harrison,

Filed *AY 5-1920*, 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5, *5*, 191*9*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 30* 191*9*, to *May 5* 191*9*, that I saw her alive on *May 2* 191*9*, and that death occurred, on the date stated above, at *4 A.* m. The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Signed) *T. J. L. Lippard* M. D.
5-5-, 191*9* (Address) *429 E. Fort Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Stanislaus *May 7, 1919*

20-UNDERTAKER

ADDRESS

*Wm. Hallowsky 1618 Eastern**ad*

D42885

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42885

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Johns Hopkins Hospital

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Chinos

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Peter Chinos

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Greece

12 MAIDEN NAME OF MOTHER

Catherine Mosaro

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Greece

14

Informant (Address)

E. E. Duncan
Johns Hopkins Hospital

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 1 1920

17

I HEREBY CERTIFY, That I attended deceased from May 1 1920, to May 1 1920, that I last saw her alive on May 1 1920, and that death occurred, on the date stated above, at 12:40 a.m.

The CAUSE OF DEATH* was as follows:

Intrauterine
Asphyxia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

John W. Harris, M. D.

(Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner Health.

W. WOODALL

5-1920 Burial Permit Clerk.

D42886

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42886

CERTIFICATE OF DEATH.

6-091

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

617 S. Luzerne St.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

James Mc Arthur

(Residence in Baltimore: No.

617 S. Luzerne St.

3 yrs., 9 mos., 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

Jul

17

1918

(Month)

(Day)

(Year)

7-AGE,

1 yrs., 9 mos., 18 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Balto. Ind.

10-NAME OF FATHER,

Stephen Arthur

11-BIRTHPLACE OF FATHER
(State or Country),

Balto Ind

12-MAIDEN NAME OF MOTHER

Rosa Horv

13-BIRTHPLACE OF MOTHER
(State or Country),

Balto Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Stephen Arthur

(Address)

612 S. Luzerne Ave.

15-

MAY 5 1920 Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

4

1920

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from April 28 1920, to May 4 1920, that I saw him alive on May 4 1920, and that death occurred, on the date stated above, at 2 p.m. The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. ca. mos. 7 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. ca. mos. 7 ds.

(Signed)

May 4, 1920

(Address)

1243 1/2 Ave.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Bernard Cemetery

DATE OF BURIAL

3/6/20

20-UNDERTAKER

J. J. Moran

ADDRESS

3000 E. Balt St.

Very important. See instructions on back of certificate. Exact statements of OCCUPATION should be properly classified.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D42882

28

D42882

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 14187 St. 15 WARD)

FULL NAME Mercedes Elizabeth Rigger

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 14187 St. 15 yrs. 6 mos. 10 ds.)

Str. 15 yrs. 6 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH OCT 25, 1901 (Month) (Day) (Year)

7-AGE 18 yrs. 6 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Telephone Operator (b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE (State or country) Baltimore Md.

PARENTS 10-NAME OF FATHER Frederick M. Rigger 11-BIRTHPLACE OF FATHER (State or country) Baltimore Md. 12-MAIDEN NAME OF MOTHER Emma Rucker 13-BIRTHPLACE OF MOTHER (State or country) Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frederick M. Rigger (Address) 1408 N. Gilman St.

15 Robert P. Harrison

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 4, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 5-1-1919, to 5-4-1920 that I saw her alive on 5-3-1920 and that death occurred, on the date stated above, at 2:10 p.m. The CAUSE OF DEATH* was as follows: Coronary Arteriosclerosis

Contributory (SECONDARY) Cardiac Asthenia (Duration) yrs. 6 mos. ds.

(Signed) Wm. J. Burpee M. D. on 4-1919 (Address) 928 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. in the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cathedral Cemetery May 7, 1920

20-UNDERTAKER ADDRESS

John J. Fisher & Sons 821 N. York St.

MAY 5 - 1920 Burial Permit REGISTRAR

D42888

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Inf. Asylum* ST.; *14* WARD)2-FULL NAME *George Franklin Shepherd Jr.*(Residence in Baltimore: No. *2937 E. Monument* St.; *8* yrs., *8* mos., *2* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

Aug. 1st, 1920
(Month) (Day) (Year)

7-AGE,

*9 yrs., 8 mos., 2 ds.*If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Geo. Franklin Shepherd*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent's Inf. Asylum*(Address) *1401 Division St.*

15-

Robert P. Harrison
MAY 5 - 1920 Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 2, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *April 1st, 1920*, to *May 1st, 1920*, that I saw him alive on *May 1st, 1920*, and that death occurred, on the date stated above, at *3 a.* m.

The CAUSE OF DEATH* was as follows:

Malnutrition(Duration) *7* yrs., *8* mos., *2* ds.CONTRIBUTORY
(Secondary)*Rickets*(Signed) *Chas. H. Davis* M. D......, 191... (Address) *1501 McMillan*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Cathedral

DATE OF BURIAL,

May 6, 1920

20-UNDERTAKER

M. F. Carey & Son

ADDRESS

1827 North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42889

CERTIFICATE OF DEATH.

151
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent & Wythe* St.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *James Mc Carver*(Residence in Baltimore: No. *1401 Division St.*St.: — yrs. *1* mos. *7* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

Mar. 25, 1920
(Month) (Day) (Year)

7-AGE,

1 mos. 7 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*None*9-BIRTHPLACE,
(State or Country),*Maryland*

PARENTS.

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*..*

12-MAIDEN NAME OF MOTHER

*Elizabeth McLane*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *St. Vincent & Wythe*(Address) *1401 Division St.*

15-

Robert P. Harrison,

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 2, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *April 12, 1920*, to *May 1, 1920*, that I saw him alive on *May 1, 1920*, and that death occurred, on the date stated above, at *1 P. M.* The CAUSE OF DEATH* was as follows:*Malnutrition*
(Duration) *16 ds.*CONTRIBUTORY
(Secondary)(Duration) *16 ds.*
(Signed) *Chas. H. Claffey, M. D.*
, 191... (Address) *1504 W. 11th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Cathedral**May 6, 1920*

20-UNDERTAKER

ADDRESS

M. Faherty & Sons 827 N. York St.

MAY 5 - 1920

1452890

HEALTH DEPARTMENT—CITY OF BALTIMORE

142890

CERTIFICATE OF DEATH.

* 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. *7th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Luke Harrison

(a) RESIDENCE. NO.

Palmer Texas ST.

WARD.

Palmer Texas

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Abbie Harrison

6 DATE OF BIRTH (month, day, and year)

Feb 24 1870

7 AGE

50

Years

2

Months

11

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Mass

10 NAME OF FATHER

Seabourne Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N. C.

12 MAIDEN NAME OF MOTHER

Kathryn Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Mass

14

Informant (Address)

Hospital Record 7-16-26

15

Filed

1926

ROBERT L. HARRISON

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 5 1920

17

I HEREBY CERTIFY, That I attended deceased from

*April 30, 1920 to May 5, 1920.*that I last saw him live on *May 5, 1920.*and that death occurred, on the date stated above, at *700 a. m.*

The CAUSE OF DEATH* was as follows:

Operation for brain tumor.

(duration)

yrs.

mos.

24 hrs.

CONTRIBUTORY (Secondary)

Brain tumor

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Yes

Date of

May 4, 20-

Was there an autopsy?

Yes

What test confirmed diagnosis?

Findings of tumor

(Signed)

Mont R. Reed

M. D.

19 (Address)

Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Dallas Texas

DATE OF BURIAL

May 5 1920

20 UNDERTAKER

Joseph Ahrens

ADDRESS

221 W. ...

D42891

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42891

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 Callow ave ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ann Miller

(a) RESIDENCE. NO.

2108 Callow ave ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

5 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofMorris Miller

6 DATE OF BIRTH (month, day, and year)

Unknown 1867

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

53

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Russia

10 NAME OF FATHER

Benj Klaff

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Ida

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant
(Address)Jack Lewis
1411 E. Baltimore

15

Filed

AY 5-1920Robert P. Harrison,

Registrar

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 2, 1920, to May 5, 1920,that I last saw him alive on May 5, 1920,and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

Hemiplegia(duration) yrs. mos. 2 1/2 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?at place of deathDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? The usual clear signs.(Signed) J. H. S. Hemmell, M. D., 19 (Address) 2226 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Rosevale CemMay 6 1920

20 UNDERTAKER

ADDRESS

Jack Lewis

D42892

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42892

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2106 Hollins

ST.

WARD)

REGISTERED NO. C

2-FULL NAME

James M. Kitzick

(Residence in Baltimore: No.

2106 Hollins

St.; 30 yrs., — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Widower

6-DATE OF BIRTH,

March 4, 1890

(Month)

(Day)

(Year)

7-AGE,

75

yrs.

24

mos.

—

ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

Night-Watchman
Manufacturers9-BIRTHPLACE,
(State or Country),

Howard Co., Md.

10-NAME OF FATHER,

Thomas M. Kitzick

11-BIRTHPLACE OF FATHER
(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Daisy Maxwell

(Address)

2106 Hollins St.

15-

Robert P. Harrison,

AY 5-1920

191

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 4, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from April 23 1920, to May 4 1920, that I saw him alive on May 3 1920, and that death occurred, on the date stated above, at 6.20 p.m. The CAUSE OF DEATH* was as follows:

Arterio Sclerosis & Myocardial Degeneration
(Duration)....yrs....mos....ds.

CONTRIBUTORY
(Secondary)Heart Bronchitis
(Duration)....yrs....mos....11 ds.

(Signed)

W. H. Kitzick

M. D.

May 4, 1920. (Address) 4107 N. Liberty St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONAL TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cemetery

DATE OF BURIAL,

May 6, 1920

20-UNDERTAKER

J. H. Offutt, Jr.

ADDRESS

2106 Hollins St.

REGISTRATION IS VERY

42989
D42893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1208 D42893

PLACE OF DEATH

CITY OF BALTIMORE (No. 1032 Emsard St.)

2-FULL NAME

(Residence in Baltimore: No. 1032 Emsard St.)

WARD

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 67 yrs., 6 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

101

ROBERT I. KRAUTER

Bureau of Vital Statistics
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an

then on and from the evidence obtained by said
find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Nephritis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed)

191

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

D42891

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

39

D42891

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

718 N. Broadway

ST.: 7

WARD)

2-FULL NAME

Sarah C. Martin

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

718 N. Broadway

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs.

mos.

14 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

Henry Martin

6 DATE OF BIRTH (month, day, and year)

April 21st 1841

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

79

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

James Crews.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Eastern Shore Maryland

12 MAIDEN NAME OF MOTHER

Catherine Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

Mrs. Bernice M. Schuch
718 N. Broadway

15

File

MAY 6 - 1920 ROBERT K. TRAUTER

Burial Permit STATE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 5 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 1, 1919, to May 5, 1920.

that I last saw her alive on May 4, 1920.

and that death occurred, on the date stated above, at 4.40 a.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of left upper maxilla, extensive tooth.

(duration) 2 yrs. + mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry C. Blyden, M. D.

, 19 (Address) 1100 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

April 7 1920

20 UNDERTAKER

ADDRESS

George Schilling & Sons 1126 E. Monument

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42895

CERTIFICATE OF DEATH.

34 D42895

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3132 Foster Ave.ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Richard Kinstler

(a) RESIDENCE. No.

3132 Foster Ave.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 31 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

Mary Almira Kinstler

6 DATE OF BIRTH (month, day, and year)

June 4, 1852

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

67111

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Day labourer

(b) General nature of industry, business, or establishment in which employed (or employer)

040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

John Kinstler

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not known

14

Informant

(Address)

Charles W. Hawkins3132 Foster Ave

15

MAY 6-1920

ROBERT H. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1920

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 1920, to May 5 1920, that I last saw him alive on May 4 1920,and that death occurred, on the date stated above, at 1:55 A m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis +
Senile debility(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic fistula of Scrotum
(Tuberculosis?) duration 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Yes (Hernia) Date of April 6

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

M. J. M. away M. D.

May 5, 1920 Address

139 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Schwartz's Cem.May 8 1920

20 UNDERTAKER

Glicker + Glicker

ADDRESS

1739 E. Cogan

D42896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42896
66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1033 St PaulST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman E Bosler(a) RESIDENCE. No. 1033 St Paul

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofCarolyn Lulamy Bosler

6 DATE OF BIRTH (month, day, and year)

July 27 1861

7 AGE

Years

Months

Days

If LESS than
1 day, ____ hrs.
or ____ min.5898

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Banker

(b) General nature of industry, business, or establishment in which employed (or employer)

Fidelity Trust Co.

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Carlisle Pa

10 NAME OF FATHER

J H Bosler11 BIRTHPLACE OF FATHER (city or town)
(State or country)Carlisle Pa

12 MAIDEN NAME OF MOTHER

Mary Jabale13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Carlisle Pa

14

Informant
(Address)6 E. Bosler
1033 St Paul St

15

Filed

MAY 6 - 1920ROBERT A. KRAUTER
RegistrarPublic Health Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 5 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 3 1920, to May 5 1920,that I last saw him alive on May 5 1920,and that death occurred, on the date stated above, at 10-15 P m.

The CAUSE OF DEATH* was as follows:

General progressive paralysis(duration) 20 yrs. mos. ds.CONTRIBUTORY
(Secondary)Oedema of Brain(duration) ____ yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Baltimore, 1900

Did an operation precede death?

No Date of ____

Was there an autopsy?

No

What test confirmed diagnosis?

None(Signed) A. D. Atkinson, M. D., 19 (Address) 610 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Landon ParkMay 7 1920

20 UNDERTAKER

Henry Jenkins - Landon

D42897

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10

D42897

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 Dolphin ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Agnes Mack

(a) RESIDENCE. No.

629 DolphinST. 11 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Isaac Mack

6 DATE OF BIRTH (month, day, and year)

July 30 1861

7 AGE

58 Years9 Months4 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balti Co. Md.

10 NAME OF FATHER

Charles Green

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Myranda LeCombe

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Myranda M. Radon
523 Westman St

15

Filed

19

MAY 6 - 1920

ROBERT A. ELLIOTT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr 9, 1920, to May 4, 1920.that I last saw her alive on May 3, 1920.and that death occurred, on the date stated above, at 10:17 A. m.

The CAUSE OF DEATH* was as follows:

Influenza(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No

(Signed)

William Frey, M. D.

19

(Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Land UnityMay 6 1920

20 UNDERTAKER

ADDRESS

John B. Owens538 Del

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42898

CERTIFICATE OF DEATH.

D42898

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 604 S. MonroST. 19

WARD)

2-FULL NAME John H. Stronger(Residence in Baltimore: No. 604 S MonroSt.; yrs., 39 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 19.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Sept111886

(Month)

(Day)

(Year)

7-AGE,

39 yrs. 8 mos. 24 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...Clarke - 609
Spice Monro

9-BIRTHPLACE, (State or Country),

Balt City

10-NAME OF FATHER,

Joseph T. Stronger

11-BIRTHPLACE OF FATHER, (State or Country),

Balt. Md

12-MAIDEN NAME OF MOTHER,

Catherine Hinder

13-BIRTHPLACE OF MOTHER, (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant: Andrew W. Stronger(Address: 28 S. Prospect St

15-

Filed

MAY 6 - 1920ROBERT E. KRAUTER101. Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May51920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest (Inquest, au-topsy or inquiry.) and that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH* was as follows:

incurable
Arch of Aorta(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Reflux of same(Duration) yrs. 2 mos. ds.(Signed) James M. Denton M. D.(Coroner.) May 5 1920 (Address) 700 E. Clarendon

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Western

DATE OF BURIAL,

May 8th 1920

20-UNDERTAKER

Arthur F. Fayer & Sons 827 North

ADDRESS

See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42899

CERTIFICATE OF DEATH

91 D42899

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.:

yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Male

White

Single

6-DATE OF BIRTH

May

30, 1860

(Month)

(Day)

(Year)

7-AGE

59

yrs.

11

mos.

4

ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Real Estate Agent

086

9 BIRTHPLACE (State or country)

Baltimore, Md.

10 NAME OF FATHER

Joseph D. Daniels

11 BIRTHPLACE OF FATHER (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Juliana Paca

13 BIRTHPLACE OF MOTHER (State or country)

Talbot Co., Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant: Mrs. Julia Daniels

(Address) 1206 McCulloh St.

15

MAY 6 - 1920

ROBERT E. KRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

4th

1920

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 30, 1920, to May 4, 1920.

that I saw him alive on May 4, 1920.

and that death occurred on the date stated above, at 2:45 p.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration)

Short time

Contributory (SECONDARY)

Asthmatic Condition

(Duration)

yrs. mos. ds.

(Signed)

Wm. M. Dannebaker

M. D.

May 4, 1920.

(Address) 209 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenmount

May 8, 1920

20-UNDERTAKER

ADDRESS

Arthur Fisher - Son 1827 N. North St.

D42900

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42900

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes Hosp.* ST. *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

File

MAY 6 - 1920

ROBERT F. LEAVER

Racial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 5 1920

17

I HEREBY CERTIFY, That I attended deceased from

*May 4 1920 to May 5 1920*that I last saw him alive on *May 5 1920*and that death occurred, on the date stated above, at *10 15 P. m.*

The CAUSE OF DEATH* was as follows:

Pneumonia(duration) yrs. mos. *4* ds.CONTRIBUTORY
(Secondary)(duration) yrs. mos. *1/2* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *History & physical finding*(Signed) *Daman P. Alexander M. D.*19 (Address) *St. Agnes Hosp.**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Peters**May 8 1920*

20 UNDERTAKER

ADDRESS

*Martin Fisher & Sons**1827 North*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42901

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1544 Bayle)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

22-FULL NAME

(Residence in Baltimore: No.

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, Male	4-COLOR OR RACE, White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married
----------------	---------------------------	---

6-DATE OF BIRTH, *Nov. 17*, *1887*
.....
(Month) (Day) (Year)

7-AGE, 69 yrs. 1 mos.ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... *Ship joining*.....

(b) General nature of industry, business, or establishment in which employed (or employer)..... *015*.....

9-BIRTHPLACE,
(State or Country), *Baltimore.*

10-NAME OF FATHER, *Maxwell L. D...*

11-BIRTHPLACE
OF FATHER
(State or Country). *Balt. Md.*

12-MAIDEN NAME
OF MOTHER *John M. C. ...*

13-BIRTHPLACE
OF MOTHER
(State or Country). *B. K. M.C.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address) 1744 12th St

18 MAY 6 - 1920 ROBERT E. KRAUTER
Filed 191

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 3, 1910
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
4/28 1920 to 5/3 1920

that I saw him alive on 5/12 1970

and that death occurred, on the date stated above, at 6:20 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration)..... yrs..... mos. 5 ds.

CONTRIBUTORY.....*Other Heart Lesion*
(Secondary) *(12)*

..... (Duration) yrs.....mos.....da.

(Signed).....J. H. Fowler.....M. D.

✓3/20 191... (Address) 1432 William

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or usual residence

10-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,

[illegible]

Ms. I. Louis. 1891. 1892.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42902

CERTIFICATE OF DEATH.

D42902

PLACE OF DEATH Standard Guano Co.

CITY OF BALTIMORE (No. Curtis Bay. ST. 6 WARD)

2-FULL NAME George Washington (C).

(Residence in Baltimore: No. 1746 Mullikin Street. St.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

50

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, Colored. 5-SINGLE, Married, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Do not know, 1 (Month) (Day) (Year)

7-AGE, 60 yrs. 7 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer. (b) General nature of industry, business, or establishment in which employed (or employer), 040

9-BIRTHPLACE, (State or Country), Virginia.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Washington (C) (wife).

(Address) 1746 Mullikin St.

15-MAY 6 - 1920 ROBERT B. KAUTES

Filed 101 Social Path Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 7th, 1919. Body found May 4th, 1920, 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry & autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally burned in fire at Standard Guano Co. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Otto M. Rembrandt M. D. (Coroner.) May 5th, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Lanier Cemetery May 6, 1920

20-UNDERTAKER ADDRESS

Richard & Gross 405 McElroy

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42903

CERTIFICATE OF DEATH.

1-PLACE OF DEATH ^{US^A} General Hospital No. 2,

CITY OF BALTIMORE: (No. Fort McHenry, Md.

ST.: 24 WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lynn H. Best, Pfc. Co. M. 21st Engrs. 3064537

(Residence ~~in Baltimore~~ 632 Victoria Street, San Antonio, Texas St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male	4-COLOR OR RACE, White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single (Write the word.)
-----------------------	----------------------------------	--

6-DATE OF BIRTH, **Unknown**, 1
(Month) (Day) (Year)7-AGE, **30** yrs. mos. ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. **Soldier in**
(b) General nature of industry, business, or establishment in which employed (or employer). **U.S. Army**9-BIRTHPLACE, (State or Country), **Missouri**10-NAME OF FATHER, **Unknown**11-BIRTHPLACE OF FATHER (State or Country), **Unknown**12-NAME OF MOTHER **Mrs. Nettie Best**
632 Victoria Street, San Antonio,13-BIRTHPLACE OF MOTHER **Unknown** **Texas**
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

MAY 6-1920 191. ROBERT R. FRAUTEE

Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, **May 5, 1920**, 191...
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from **Dec. 23, 1919** to **May 5, 1920** 191... that I saw him alive on **May 5, 1920** 191... and that death occurred, on the date stated above, at **3:30 A.M.**

The CAUSE OF DEATH* was as follows:

† Carcinoma (Epithelioma) submaxillary left side, with metastasis to mandible.

..... (Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary).....

..... (Duration)..... yrs. mos. ds.

(Signed) **Thomas J. Leary, Major, 1st Corp.**
May 5, 1920 (Address) **Ft. McHenry, Md.**

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

National Cemetery**May 6, 1920**

20-UNDERTAKER

ADDRESS **1127 E****Max Johnson****Balto St**

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42904

CERTIFICATE OF DEATH.

28

D42904

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Missie Tilman(a) RESIDENCE. No. 914 Boyd St.

(Usual place of abode)

ST. 18 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown6 DATE OF BIRTH (month, day, and year) 1893

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Factory work

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Tom Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Betty Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

Hospital Records
M. T. H.

15

Filed MAY 6 - 1920ROBERT E. KAUFMANSerial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4th 1920

17

I HEREBY CERTIFY, That I attended deceased from October 27th 1919 to May 4th 1920that I last saw her alive on May 4th 1920and that death occurred, on the date stated above, at 12.45 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 1 yrs. 8 mos. ds.CONTRIBUTORY Tuberculous enteritis (Secondary)(duration) 2 yrs. mos. ds.

18 Where was disease contracted

if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum(Signed) Geo. R. Wilkinson, M. D.5-4-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND.MAY 6 - 1920

20 UNDERTAKER

ADDRESS

Commissioner Health

Per. Wm. S. Wormald

D42903

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42903

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

1920

Robert P. Harrison,

191

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractures, hit by Automobile
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner) 5-6-1920 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER,

ADDRESS

D42906

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42906

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Hope Hosp*)

2-FULL NAME

(Residence in Baltimore: No. *1406 E Fayette St*)WARD) *5*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) *Single*

6-DATE OF BIRTH,

*Feb 16**St. Louis*

1899

(Month)

(Day)

(Year)

7-AGE,

21

yrs.

2

mos.

16

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

*Laborer**040*

(b) General nature of industry, business, or establishment in which employed (or employer).

Sailor, Seaman

9-BIRTHPLACE,

(State or Country),

Phila PA

10-NAME OF FATHER,

*Bernard**Rosenstein*

11-BIRTHPLACE OF FATHER

(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

*Ada**Wolf*

13-BIRTHPLACE OF MOTHER

(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J Lewis*(Address) *1411 E Baltimore*

15-

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*May**1*

1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

*Transmitted by**Automobile*

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Harry J. Lewis*

(Coroner)

M. D.

191 (Address) *1411 E Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Philadelphia, Penna.**May 1, 1920*

20-UNDERTAKER

ADDRESS

*Jack Lewis**1411 E Baltimore*

MAY 6 - 1920

D42903

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42903

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Unaniversity Hospital* ST. *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mattie R. Robinson

(a) RESIDENCE. No.

Jamaica Va

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

C.

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Goin Robinson

6 DATE OF BIRTH (month, day, and year)

April 1875

7 AGE

45

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va.

10 NAME OF FATHER

James Reed

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va

12 MAIDEN NAME OF MOTHER

Laura Chamberlain

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va

14

Informant (Address)

*Emma L Harris**Va*

15

Y 6-1920

*Robert*Burial Permit *Clark* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-4 1920

17

I HEREBY CERTIFY, That I attended deceased from

*April 29 1920 to May 4 1920*that I last saw him alive on *May 4 1920*and that death occurred, on the date stated above, at *3 a.m.*

The CAUSE OF DEATH* was as follows:

Cancer Cervix Uteri

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Pulmonary Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Va

Did an operation precede death?

Yes

Date of

May 30, 1920

Was there an autopsy?

No

What test confirmed diagnosis?

Microscopic

(Signed)

Dr. Arthur Weinstock

M. D.

19 (Address)

Univ. Wash.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mattie Reed Malle Va May 6 1920

20 UNDERTAKER JAMES H. DENNIS ADDRESS

1303 PRESTMAN ST.

D42908

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42908

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2215 D and Hill ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Daughter of Richard & Marguerite Jones

(a) RESIDENCE. NO.

2215 D and Hill ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

1/2 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 5, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, 12 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

2215 D and Hill
Baltimore Md.

10 NAME OF FATHER

Richard Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Hamester Co
Virginia

12 MAIDEN NAME OF MOTHER

Marguerite An Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Hamester Co
Virginia

14

Informant (Address)

Marguerite An Jones
2215 D and Hill

15

Filed

Y 6-1920Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1920

17

I HEREBY CERTIFY, That I attended deceased from May 5, 1920, to May 6, 1920, that I last saw him alive on May 6, 1920, and that death occurred, on the date stated above, at 5 A. m. The CAUSE OF DEATH* was as follows:Premature Birth (6 mos),
Inflammatory Rheumatism Maternal

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

Chemical

(Signed)

Wm. H. Wright, M. D.May 6, 1920 (Address) 1209 Presbman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St Peters

DATE OF BURIAL

MAY 6 - 1920

20 UNDERTAKER

JAMES H. DENNIS

ADDRESS

1303 PRESTMAN ST.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42909

D42909

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1114 Marshall*St.: *73* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1114 Marshall*St.: *30* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Married*

6-DATE OF BIRTH.

March 17, 1859
(Month) (Day) (Year)

7-AGE.

*61 yrs. 1 mos. 18 ds.*If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Fruit Dealer
Retail 020*9-BIRTHPLACE,
(State or Country),*Italy*

10-NAME OF FATHER,

*Samuel Patti*11-BIRTHPLACE OF FATHER
(State or Country),*Italy*

12-MAIDEN NAME OF MOTHER

*Michaelena Comelli*13-BIRTHPLACE OF MOTHER
(State or Country),*Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jos. Patti*(Address) *1114 Marshall St.*

15-

Filed *1920*

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 5, 1920
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *May 2* 19*20*, to *May 5* 19*20*, that I saw him alive on *May 5* 19*20*, and that death occurred, on the date stated above, at *3:30* m.

The CAUSE OF DEATH* was as follows:

Cholera, Hemiplegia
(Duration) ... yrs. ... mos. *3* ds.CONTRIBUTORY
(Secondary)*Return Cholera*
(Signed) *Wm. B. Rott* M. D.
May 6, 1920 (Address) *1703 E. 1st St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cem.

DATE OF BURIAL,

May 7, 1920

20-UNDERTAKER

McG. Flynn

ADDRESS

1422 Highland St.

D42910

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42910

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 Hanover ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William R. C. Czichas(a) RESIDENCE, No. 1405 Hanover ST. 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23/197 AGE Years Months Days If LESS than 1 day. hrs. or min. 8 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.10 NAME OF FATHER Richard Czichas11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Margaret Schmidt13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant Mrs Czichas (Address) 1405 Hanover St15 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 192017 I HEREBY CERTIFY, That I attended deceased from April 25, 1920, to May 6, 1920, that I last saw him alive on May 5, 1920and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) R. E. Campbell M. D.Address 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross Cem. A.C.May 7 1920

20 UNDERTAKER

ADDRESS

M. J. Gynn1425 Light

D42911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42911

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Aged Marie Home* ST.: *19* WARD)2-FULL NAME *Wm. J. McCullough*(Residence in Baltimore: No. *1400 W. Lexington* St.: *9* yrs., *4* mos., *1* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*Wt*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH

Jan 5, 183*0*
(Month) (Day) (Year)

7-AGE,

90 yrs., *4* mos., *1* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
*000*9-BIRTHPLACE,
(State or Country),*Balt. Md*

PARENTS.

10-NAME OF FATHER,

Wm. J. McCullough

11-BIRTHPLACE OF FATHER

(State or Country), *Balt. Co. Md*

12-MAIDEN NAME OF MOTHER

Ann Murphy

13-BIRTHPLACE OF MOTHER

(State or Country), *Balt. Co. Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm. J. W. Tilton*(Address) *W. J. W. Tilton*

15-

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 6, 19*40*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 1, 191*0*, to *May 6*, 191*0*,that I saw h..... alive on *May 6*, 191*0*,and that death occurred, on the date stated above, at *2 P.* m.

The CAUSE OF DEATH* was as follows:

Organic disease of Heart
Arterio Sclerosis
Hypertension
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY
(Secondary)*Palmar Eczema*
(Duration)..... yrs..... mos..... ds.
(Signed)..... M. D.
May 6, 191*0* (Address) *939 W. Fayette*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *5* yrs..... mos..... ds. In the State..... yrs..... mos..... ds.Where was disease contracted, if not at place of death? *at the Home*

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

St. Charles Cemetery

DATE OF BURIAL,

May 7, 191*0*

20-UNDERTAKER

Wm. J. W. Tilton

ADDRESS

W. J. W. Tilton

MAY 8-1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42912

D42912

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 727 S. Lakewood Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Ellen S. Andrews(Residence in Baltimore: No. 727 S. Lakewood Ave St.; 30 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

July 27, 1866
(Month) (Day) (Year)

7-AGE,

53 yrs., 9 mos., 8 ds.

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

SWK 037

(b) General nature of industry, business, or establishment in which employed (or employer).

at home9-BIRTHPLACE,
(State or Country),Phila. Pa

PARENTS.

10-NAME OF FATHER,

? Nugent11-BIRTHPLACE OF FATHER
(State or Country),Ireland

12-MAIDEN NAME OF MOTHER

?13-BIRTHPLACE OF MOTHER
(State or Country),Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

R. B. Andrews

(Address).....

727 S. Lakewood Ave

15-

Robert P. Harrison,

AY 6-1920

191.....

Burial Permit ...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 4, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 1st 1920, to May 4th 1920,that I saw her alive on May 3rd 1920,and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....D. W. Jones.....M. D.5/5/20, 1920. (Address).....1015 S. Lakewood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

BaltimoreMay 6, 1920

20-UNDERTAKER

ADDRESS

Andrews & Sons 57 S. Main St

D42913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42913

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 Calver Ave ST.; 12 WARD)2-FULL NAME William C. Harrison(a) RESIDENCE. No. 716 Calver Ave ST., 12 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of William C. Harrison6 DATE OF BIRTH (month, day, and year) Aug 15 18707 AGE Years 47 Months 9 Days 22 If LESS than 1 day, 0 hrs. 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) 039

(c) Name of employer

9 BIRTHPLACE (city or town) San Diego, Cal.
(State or country)10 NAME OF FATHER Robert P. Harrison11 BIRTHPLACE OF FATHER (city or town) Cal.
(State or country)12 MAIDEN NAME OF MOTHER Isabel Williams13 BIRTHPLACE OF MOTHER (city or town) Cal.
(State or country)

14

Informant Robert P. Harrison
(Address) 716 Calver Ave15 May 6 1920 Robert P. Harrison,
1920 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 192017 I HEREBY CERTIFY, That I attended deceased from Nov 18 1918, 1918, to May 5 1920, 1920.that I last saw her alive on Aug 5 1920, 1920.and that death occurred, on the date stated above, at 10:30 m.

The CAUSE OF DEATH* was as follows:

Fibroma of Uterus & Ovaries
(duration) yrs. 6 mos. 0 ds.CONTRIBUTORY
(Secondary)(duration) yrs. 0 mos. 0 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? None(Signed) W. H. Harrison, M. D.75, 1920 Address 701 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL BurialDATE OF BURIAL May 6 192020 UNDERTAKER W. H. HarrisonADDRESS 701 E 25th St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should
Exact statement of OCCUPATION
Very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

D42914

43 D42914
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 409 North Schroeder St.)

2-FULL NAME

(Residence in Baltimore: No. 409 N. Schroeder Street-78

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str.: 78 yrs. — mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-~~SINGLE~~
MARRIED
~~WIDOWED~~
OR ~~DIVORCED~~
(Write the word)

Married

6-DATE OF BIRTH

May 6, 1942
(Month) (Day) (Year)

7-AGE

78 yrs. — 5 mos. 5 ds. If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None 037

9-BIRTHPLACE
(State or country)

Baltimore MD

10-NAME OF FATHER

John Hoater

11-BIRTHPLACE OF FATHER
(State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Sarah Unknown

13-BIRTHPLACE OF MOTHER
(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. D. Bloore

(Address)

409 N. Schroeder St.

15-

Filed

MAY 7-1920

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 6, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 6, 1920, to May 6, 1920,

that I saw him alive on May 5, 1920,

and that death occurred, on the date stated above, at 8:00 m.

The CAUSE OF DEATH* was as follows:

Cancer of Lung

(Duration) 6 yrs. — mos. — ds.

Contributory
(SECONDARY)

(Duration) — yrs. — mos. — ds.

(Signed) Henry M. Stevenson M. D.
5/6, 1920 (Address) 10220 Lafayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

May 8, 1920

20-UNDERTAKER

Geo W Little

ADDRESS

531 Fremont Ave

D42915

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42915

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 54 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED, WIDOWED,
OR DIVORCED,
(Write the word.)

Widow

6-DATE OF BIRTH,

Sept 11, 1846
(Month) (Day) (Year)

7-AGE,

73 yrs. 7 mos. 25 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Germany

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Louisa Iglschast

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

Filed

MAY 7 - 1920

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 5, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to May 6, 1920, that I saw her alive on May 5, 1920, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

Right Hemisphere

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

56, 1920 (Address) 2034 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Carmel

DATE OF BURIAL,

May 8, 1920

20-UNDERTAKER

Robt S. Little

ADDRESS

531 St. Remond Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42916

CERTIFICATE OF DEATH.

104 D42916

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 E Federal St. ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vivian Kelly Island(a) RESIDENCE. No. 420 E Federal St. ST. 12 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 14th 19097 AGE Years 1 Months 1 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. no

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer no9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland10 NAME OF FATHER Thomas Island11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland12 MAIDEN NAME OF MOTHER Rachel Kelly13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)14 Informant Thos. Island (Address) 420 E Federal

15 MAY 7 - 1920 ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5th 192017 I HEREBY CERTIFY, That I attended deceased from April 24th 1920, to May 5th 1920, that I last saw him alive on May 4th 1920, and that death occurred, on the date stated above, at 1:00 m.

The CAUSE OF DEATH* was as follows:

Acute capillary Bronchitis and Gastric Ulcer

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cold and irregular temperature (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? at place of deathDid an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? physical examination(Signed) Dr. Stael M. D.May 5 1920 (Address) 420 E Federal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

My Auburn Lane May 7 1920

20 UNDERTAKER ADDRESS

Samuel H. Newley 578 N. E. St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42912

D42912

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *U. S. Marine Hospital*)

2-FULL NAME

(a) RESIDENCE. No. *U. S. Marine Hospital*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. If of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Lukman*6 DATE OF BIRTH (month, day, and year) *70?*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Seaman*(b) General nature of industry, business, or establishment in which employed (or employer) *B. C. & A. Ry Co.*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Virginia*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*

14

Informant (Address) *Hospital Records*

15

MAY 7-1920

ROBERT E. LEADLEY

Serial Permit 0107

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 4 1920*

17

I HEREBY CERTIFY, That I attended deceased from *May 3rd* 19*20* to *May 4* 19*20* that I last saw him alive on *May 4* 19*20* and that death occurred, on the date stated above, at *4:30 P. M.* The CAUSE OF DEATH* was as follows:** Terminal pneumonia, tracheitis*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death? *On boat*Did an operation precede death? *No* Date of *7-10*Was there an autopsy? *Yes*What test confirmed diagnosis? *Aspiration*(Signed) *Chas. H. Wogel*

M. D.

5-4-1920 Address *U. S. Marine Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Graincock, A. A. Co.*DATE OF BURIAL *May 8 1920*20 UNDERTAKER *Samuel Hunsley*ADDRESS *57 E. B. St.*

D42918

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42918

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula Dorsey(a) RESIDENCE. NO. 804 Pierce St.

ST. _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Unknown

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown6 DATE OF BIRTH (month, day, and year) 1895

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland10 NAME OF FATHER Charles Dorsey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland12 MAIDEN NAME OF MOTHER Florence Myers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland14 Informant Hospital Records

(Address)

M.T.H.

15

Filed

MAY 7 - 1920ROBERT R. TRAUTMANAsst. Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5th, 1920

17

I HEREBY CERTIFY, That I attended deceased from March 8th, 19 20, to May 5th, 19 20,that I last saw him alive on May 5th, 19 20,and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 6 yrs. 6 mos. 6 ds.CONTRIBUTORY Endocarditis (Secondary)(duration) Unknown yrs. Unknown mos. Unknown ds.

18 Where was disease contracted

if not at place of death? UnknownDid an operation precede death? No Date of _____Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

George R. Wilkerson, M. D.

5-6-20

(Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. AuburnMay 8 1920

20 UNDERTAKER

ADDRESS 142John H. ToadernWhitcomb

D42919

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42919

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *15 Joseph Haspelt St.*)

WARD)

2-FULL NAME

Agnese Sobus(Residence in Baltimore: No. *1627 Lancaster St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *3* yrs., *11* mos., *19* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

May 19, 1916
(Month) (Day) (Year)

7-AGE,

3 yrs., *11* mos., *19* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Child

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Joseph Sobus

11-BIRTHPLACE OF FATHER (State or Country),

Austria Poland

12-MAIDEN NAME OF MOTHER

Mary Kasper

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joseph Sobus

(Address)

1627 Lancaster St.

MAY 7-1920

ROBERT H. LAUTER

Filed

191

Bureau of Health

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 6, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an...
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said...
(Inquest, au-...and that said deceased came to...death
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

*Burns, while playing
with matches*

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Signed) *R. H. Lauter* M. D.
(Coroner.)191... (Address) *1627 Lancaster St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

May 7, 1920

20-UNDERTAKER

M. F. Sadowski

ADDRESS

705 S. Ann St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42920

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

Hebrew Hospital

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Albert Giebel

(Residence in Baltimore: No.

2407 E Chase St

St. 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Widowed

6-DATE OF BIRTH,

Apr 24, 1885

(Month)

(Day)

(Year)

7-AGE,

64

yrs.

12

mos.

ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE,
(State or Country),

Germany

10-NAME OF FATHER,

Don't know

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Eason

(Address)

2407 E Chase St

15-

MAY 7 - 1920

ROBERT E. KEAUFER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 6

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

4-23-1920, to 5-6-1920,

that I saw him alive on May 6, 1920,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration)....yrs....mos....ds.

CONTRIBUTORY
(Secondary)

Bronchopneumonia

(Duration)....yrs....mos....ds.

(Signed).....M. D.

May 6, 1920

(Address).....Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

2407 E Chase St

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Pauls Cem.

May 10, 1920

20-UNDERTAKER

ADDRESS

Wm Pook

502 E North

% Arthur K. Hartzell Via P. R. R. Gura Hartzell

Spec. 6-11-19 H. P. Co. 1000 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42921

CERTIFICATE OF DEATH.

D42921

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp* ST. *13* WARD)

2-FULL NAME

Jura Hartzell

(a) RESIDENCE, NO. *2321 Madison Ave.* ST. *13* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *15* yrs. mos. ds.

How long in U. S., if of foreign birth? *15* yrs. mos. ds.

REGISTERED NO. *79*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

None

6 DATE OF BIRTH (month, day, and year) *18 5 2*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

58 yrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

A. W. 050

(b) General nature of industry, business, or establishment in which employed (or employer)

Manager

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pa

10 NAME OF FATHER

Her Frederick Hartzell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa

12 MAIDEN NAME OF MOTHER

Mary Gaudner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa

14

Informant (Address)

Arthur K. Hartzell 2915 E. McElderry St.

15

File

MAY 7 - 1920

ROBERT B. TRAUTMAN

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 6 19 20*

17

I HEREBY CERTIFY, That I attended deceased from

May 6 19 20, to *May 6 19 20*,

that I last saw him alive on *May 6 19 20*,

and that death occurred, on the date stated above, at *5 P. M.*

The CAUSE OF DEATH* was as follows:

Myocardial Infarct

(duration) yrs. mos. ds.

CONTRIBUTORY *Valvular Heart Disease* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

no

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Physical examination

(Signed)

Samuel Thuermer, M. D.

19 (Address)

St. Joseph's Hospital

*State the Disease Causing Death, in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Carlisle Pa May 7/19 20

20 UNDERTAKER

ADDRESS

Wm. Cook 5026 North Ave

D42922

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

63 D42922

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 E. Pratt St ST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

MIRSH MIRVIS

(a) RESIDENCE. No.

1001 E. Pratt St

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

19

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

19

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown 1840

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.80——

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Rev. x

(b) General nature of industry, business, or establishment in which employed (or employer)

Hebrew

(c) Name of employer

Teacher9 BIRTHPLACE (city or town)
(State or country)Russia

10 NAME OF FATHER

Rubin Mirvis

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Cherna

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant
(Address)J. Lewis
1411 E. Pratt St

15

Filed

MAY 7 - 1920ROBERT E. KRAUTER

Registrar

Serial 21111 1101

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-61920

17

I HEREBY CERTIFY, That I attended deceased from

1916, toMay 61920

that I last saw him alive on

May 61920

and that death occurred, on the date stated above, at

1015 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral arteriosclerosisDementia (senile)(duration) 4+ yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)Symptoms of bulbarparalysis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

143 S. Central av.

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

Frank R. Smith

M. D.

19 (Address)

1126 Cathedral Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Sanitation Co.5/71920

20 UNDERTAKER

Jack Lewis

ADDRESS

1411 E. Pratt

D42923

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42923

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 E. Fayette St. ST. 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Rose Kirschner

(a) RESIDENCE. NO.

918 E. Fayette St. ST. 5 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Unknown mos.

ds.

How long in U. S., if of foreign birth?

30 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown/1859

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

60——

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Abraham David

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Lohia Makki

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant

J. Lewis

Filed

19

ROBERT A. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 6 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 5, 1920, to May 5, 1920,that I last saw her alive on May 5, 1920,and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Myocarditis
+ Nephritis(duration) 6 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

At Home 918Did an operation precede death? NO Date of —Was there an autopsy? NOWhat test confirmed diagnosis? Examination(Signed) E. W. McCafferty, M. D., 19 (Address) 1415 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Heaven Washington5/7 1920

20 UNDERTAKER

ADDRESS

J. Lewis1411 E. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42924

CERTIFICATE OF DEATH.

170
REGISTERED NO. C

D42924

1-PLACE OF DEATH

Union Protestant Infirmary

CITY OF BALTIMORE: (No.

1514 Stinson

ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Benjamin Katz

(Residence in Baltimore: No.

2119 Pennsylvania Avenue

St.; 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

Russian Jew.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH.

Unknown

1867?

(Month)

(Day)

(Year)

7-AGE.

53 yrs. ? mos. ? ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Shoe-maker

(b) General nature of industry, business, or establishment in which employed (or employer).

088

9-BIRTHPLACE.

(State or Country),

Russia.

PARENTS.

10-NAME OF FATHER,

? Katz

11-BIRTHPLACE OF FATHER

(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Goldie ?

13-BIRTHPLACE OF MOTHER

(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

MAY 7 - 1920

ROBERT E. LAUTER

Filed....., 191

Burial Park, Baltimore

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 7th, 1920.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 6, 1920, to May 7th, 1920,that I saw him alive on May 7th, 1920,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis with total suppression of urine and uremia.

(Duration)..... yrs. mos. 7 ds.

CONTRIBUTORY.....

(Secondary)

nephritis..... (Duration).... 11 yrs. mos. ds.

(Signed).....

M. D.

May 7th, 1920. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the ?

Where was disease contracted, if not at place of death? Home

Former or usual residence..... 2119 Pennsylvania Ave. Balt.

19-PLACE OF BURIAL, OR REMOVAL,

Whelan Herring Run

DATE OF BURIAL,

5/7, 1920

20-UNDERTAKER

Jack Lewis

ADDRESS

1411 E. Balt.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42925

CERTIFICATE OF DEATH.

10-090

D42925

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 Thirteenth ST.; 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Friedrich Brochlander

(a) RESIDENCE, No. 524 Thirteenth ST., 26 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male White Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

the late Maggie Brochlander

6 DATE OF BIRTH (month, day, and year)

April 5 1861

7 AGE

59

Years

1

Months

1

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

Copperworks

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md

10 NAME OF FATHER

Friedrich Brochlander

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Kate Ballhof

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant
(Address)Mrs Ferdinand Wehr
524 S 13th Street

15

Filed

MAY 7 - 1920

ROBERT R. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 18 1920, to May 6 1920

that I last saw him alive on May 5 1920

and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis
Sputum examination negative
(duration) yrs. 2 mos. 17 ds.CONTRIBUTORY
(Secondary)Influenza
(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) D.W. Jones, M. D.

5/7 1920 (Address) 1013 D. Oldwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Fifth German Reformat May 9 1920

20 UNDERTAKER

ADDRESS

Louis's Hermann 323 Brossa way

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42926

CERTIFICATE OF DEATH.

32
D42926
REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1035 S. Howard ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellie Aulton(Residence in Baltimore: No. 1035 S. Howard St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. Colored 5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH, December 17 1900
(Month) (Day) (Year)7-AGE, 20 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0869-BIRTHPLACE, (State or Country), Baltimore Md.10-NAME OF FATHER, James Aulton11-BIRTHPLACE OF FATHER (State or Country), Calvert Co. Md.12-MAIDEN NAME OF MOTHER, Ellie Smith13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Ellie Aulton(Address) 1035 S. Howard St.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 5 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 15 1920, to May 5 1920,
that I saw him alive on May 4 1920,
and that death occurred, on the date stated above, at 2300 hrs.

The CAUSE OF DEATH* was as follows:

acute cystitis
effusion and infection
of pyogenic origin
(Duration)..... yrs. mos. ds.CONTRIBUTORY.....
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed)..... J. L. Parham..... M. D...... May 6 1920 (Address) 1812 Blenheim

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Albans DATE OF BURIAL, May 7 192020-UNDERTAKER R. L. Parham ADDRESS 1812 Blenheim

MAY 7 1920

ROBERT A. KAUTER
Burial Form No. 1

D42927

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42927

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 146 W. HareST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Erdbrink

(a) RESIDENCE. No.

146 W. HareST., 6 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 50 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Annie Erdbrink

6 DATE OF BIRTH (month, day, and year)

1863

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

57

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Asst. Engineer at

(b) General nature of industry, business, or establishment in which employed (or employer)

Munsey Bld.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germa.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germa.

14

Informant (Address)

Annie Erdbrink
146 W. Hare St.

15

Filed MAY 7 - 1920

ROBERT K. KRAUTER

Registrar

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 19 20

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 3 19 20, to May 6 19 20that I last saw him alive on May 5 19 20.and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

DiabetesCONTRIBUTORY (Secondary) Diabetes (duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Yes

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Chemical tests

(Signed)

Leo. Heller

M. D.

5-7-1920 (Address)

1437 Gough St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn Cem.

DATE OF BURIAL

May 10 - 1920

20 UNDERTAKER

Lilly & Zeller

ADDRESS

400 S. Myrtle St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42928

D42928

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Reisterstown Road & Allen St.* ST. *15* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Henry Francis Rieffe

(a) RESIDENCE. NO.

Reisterstown Rd. & Allen St. ST. *15* WARD.

(Usual place of abode)

(Resident)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *81* yrs. *6* mos. *17* ds. How long in U. S., if of foreign birth? *81* yrs. *6* mos. *17* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Sarah Frances Rieffe*6 DATE OF BIRTH (month, day, and year) *Oct-18-1838*7 AGE Years *81* Months *6* Days *17* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired 013

(b) General nature of industry, business, or establishment in which employed (or employer)

Butcher

(c) Name of employer

Self

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Henry F. Rieffe

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Forzheim Germany

12 MAIDEN NAME OF MOTHER

Jacobina Pohrbader

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baden Baden Germany

PARENTS

14 Informant (Address)

Mr. James F. Rieffe (Son) 3801 Liberty Heights Rd

MAY 7-1920

ROBERT I. TEADIE Registrar
Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 5* 19*20*17 I HEREBY CERTIFY, that I attended deceased from *May* 19*19* to *May 5* 19*20*that I last saw him alive on *May 5* 19*20*

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Retraumatic gout, with deformity of bones of chest & skull &ankylosis of smaller joints (duration) *2* yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of _____Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Robert F. Teadie* M. D., 19 (Address) *Main & Hay road*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Green Mount Cemetery
20 UNDERTAKER
STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)*May 8* 19*20*
ADDRESS
108 W. NORTH AVE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42929

CERTIFICATE OF DEATH.

X 91-078

D42929

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 309 West Hoffman St. ST.; 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Drury Waldron

230 West 97th. St.

(a) RESIDENCE. NO. New York, N. Y.

(Usual place of abode)

ST.,

WARD

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

1

mos.

22

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 6, 1907

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

13

1

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Boston, Mass.
(State or country)

10 NAME OF FATHER John Waldron

11 BIRTHPLACE OF FATHER (city or town) Liverpool, England
(State or country)

12 MAIDEN NAME OF MOTHER Helen Davis

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.
(State or country)

14 Informant Mrs. Helen Waldron

(Address) 230 West 97th. St., New York

15 Filed MAY 7-1920 ROBERT A. KRAUTH

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 - 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 24, 1920, to May 5, 1920,

that I last saw him alive on May 5, 1920,

and that death occurred, on the date stated above, at 4:20 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. 1 mos. 18 ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Pettit, M. D.

, 19 (Address) 817 Hamilton Ten

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

May 8, 1920

20 UNDERTAKER

ADDRESS

Henry W. Mears & Son

805 N. Calver

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42930

CERTIFICATE OF DEATH.

REGISTERED NO.

D42930

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospitals* ST. *4* WARD)

2-FULL NAME

Mrs Martha Visnanskas

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. *750 W. Lexington* ST. *4* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *20* yrs. mos. ds.How long in U. S., if of foreign birth? *20* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White Lithuanian

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

No

6 DATE OF BIRTH (month, day, and year)

1873

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

48

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

837

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Lithuania

10 NAME OF FATHER

M. Cepelinskas

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Lithuania

12 MAIDEN NAME OF MOTHER

R. Pocklewece

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Lithuania

Informant (Address)

John Visnanskas 750 W. Lexington St

MAY 7 - 1920

ROBERT E. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5/6/1920

17

I HEREBY CERTIFY, That I attended deceased from

*April 29, 1920, to May 6, 1920.*that I last saw her alive on *May 6, 1920*and that death occurred, on the date stated above, at *4 a* m.

The CAUSE OF DEATH* was as follows:

Septic Encephalitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocardial infarct

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *Home*Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Chas R. Gold Barragh, M. D.*, 19 (Address) *University Hospitals*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Stanislovas**May 10 1920*

20 UNDERTAKER

ADDRESS

John Gebliancas 425 S. Prag

HEALTH DEPARTMENT—CITY OF BALTIMORE

1042931

CERTIFICATE OF DEATH.

D42931

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *7th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *George C. Gorer*(a) RESIDENCE. NO. *5439 Swiss Ave Dallas Texas* ST. WARD. *Dallas Texas*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Apr. 24. 1862*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*59**15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Judge 086 of Court*9 BIRTHPLACE (city or town) (State or country) *Texas*10 NAME OF FATHER *Louis J. Gorer*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Texas*12 MAIDEN NAME OF MOTHER *Maria B. McLaughlin*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Pa.*14 Informant (Address) *2444 Bkms.*

MAY 7-1920

ROBERT B. KAUTER
Registrar
Baltimore

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 8 1920*

17

I HEREBY CERTIFY, That I attended deceased from April 2nd, 1920, to May 8, 1920, that I last saw him alive on May 7, 1920, and that death occurred, on the date stated above, at 4:15 a. m.

The CAUSE OF DEATH* was as follows:

Pericious Anemia

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 6 mos. ds.

Pulmonary Tbc.

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Texas*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Wm S. Tillet*, M. D.May 7 1920 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Dallas Texas**May 7 1920*

20 UNDERTAKER

Henry S. Jenkins & Son Co. 1000 Mar. Coll. St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42932

CERTIFICATE OF DEATH.

81
REGISTERED NO.

D42932

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107-N. Milton Ave ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Helene Kreuzer

(a) RESIDENCE. NO.

1107-N. Milton Ave ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? 2 yrs. 3 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 Single, Married, Widowed, or Divorced (write the word)Widow

5a If married, widowed, or divorced

WIFE ofJohn Kreuzer

6 DATE OF BIRTH (month, day, and year)

11-27-1837

7 AGE

82

Years

Months

5

Days

8If LESS than 1 day 2 hrs. or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Honorary

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Berj Weidentemper

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

(Address)

Mary A. Miller
1839-N. Collins Ave

Filed

1920

19

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 - 1920

17

I HEREBY CERTIFY, That I attended deceased from May 4, 1920, to May 5, 1920, that I last saw her alive on ", 1920, and that death occurred, on the date stated above, at 3 P. m. The CAUSE OF DEATH* was as follows:Arterial Sclerosis
(General no hemorrhage)(duration) 5 yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ---Was there an autopsy? noWhat test confirmed diagnosis? none(Signed) Edwin B. Tenby, M. D.5/7, 1920 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer CemeteryMay 8th 1920

20 UNDERTAKER

ADDRESS

George J. Ryeth1735 Hayford

D42933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 115 D42933

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

7 ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

2.

4 COLOR OR RACE

24.

5 Single, Married, Widowed, or Divorced (write the word)

m.

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Mr. Charles Rife

6 DATE OF BIRTH (month, day, and year)

1865

7 AGE

Years

Months

Days

If LESS than
1 day. hrs.
or min.

55 yrs

?

?

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Penna.

10 NAME OF FATHER

No not know

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant
(Address)Mr. Chas. Rife
Fairfield Adams Co Penna

May 1920 Robert P. Harrison

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 6, 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr 30, 1920, to May 6, 1920.

that I last saw her alive on May 6, 1920.

and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis following Gall
bladder operation

(duration)

yrs.

mos.

3 ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

At place of death

Did an operation precede death?

yes Date of May 4, 1920.

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical symptoms

(Signed)

Frank V. Lacey, M. D.

, 19

(Address)

St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Fairfield Adams Co Penna

5-8th 1920

20 UNDERTAKER

Robert Brooks & Son

ADDRESS

Cathlamet
Hollins

D42934

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42934

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Viola Shores(a) RESIDENCE. NO. 2413 Guilford Ave ST. _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>married</u>
------------------------	---------------------------------	--

5a If married, widowed, or divorced
HUSBAND of Henry A. Shores
(or) WIFE of6 DATE OF BIRTH (month, day, and year) March 18, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
	<u>23</u>	<u>0</u>	<u>24</u>	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) Delta Pa.
(State or country)10 NAME OF FATHER Wm. O. Myers11 BIRTHPLACE OF FATHER (city or town) Woodstock
(State or country) Pa.12 MAIDEN NAME OF MOTHER Florence E. Tucker13 BIRTHPLACE OF MOTHER (city or town) Forest Hill
(State or country) Md.14 Informant W.O. Myers
(Address) 2413 Guilford Ave15 Robert P. Harrison,

AY 7-1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1920

17 I HEREBY CERTIFY, That I attended deceased from
May 4, 1920, to May 7, 1920,
that I last saw her alive on May 7, 1920,
and that death occurred, on the date stated above, at 7.05 A. M.

The CAUSE OF DEATH* was as follows:

Hyperemesis gravidarum(duration) _____ yrs. 1 mos. 14 ds.CONTRIBUTORY Post operative shock
(Secondary)(duration) _____ yrs. _____ mos. 1 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? Yes Date of May 6, 1920Was there an autopsy? NoWhat test confirmed diagnosis? Clinical findings(Signed) J. A. Bunchess, M. D., 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Delta PaMay 1920

20 UNDERTAKER

ADDRESS

Clash Johnson1442 7th Ave

D42935

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42935

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 Connet ST.; 5 WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. 1123 Connet St.; 5 yrs., 12 mos., 6 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

M

4-COLOR OR RACE

W5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Apr 24, 1886
(Month) (Day) (Year)

7-AGE

31 yrs., 12 mos., 6 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Operator
Operator9-BIRTHPLACE,
(State or Country),Baltimore

PARENTS.

10-NAME OF FATHER,

John J. Smith11-BIRTHPLACE OF FATHER
(State or Country),Massachusetts

12-MAIDEN NAME OF MOTHER

Mary M. Sullivan13-BIRTHPLACE OF MOTHER
(State or Country),Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mrs. Margaret Miller1123 Connet St.

15-

Robert P. Harrison,

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 6, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 1, 1918, to May 6, 1920,that I saw him alive on May 6, 1920,and that death occurred, on the date stated above, at 89 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 2 yrs., 12 mos., 6 ds.CONTRIBUTORY
(Secondary)(Duration) 1 yr., 12 mos., 6 ds.(Signed) Robert J. Green, M. D.5- 6, 1920 (Address) 120 1/2 Disgrace St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 1 yrs., 12 mos., 6 ds. In the State 1 yrs., 12 mos., 6 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Catharine's

DATE OF BURIAL,

May 8, 1920.

20-UNDERTAKER

Robert J. Green

ADDRESS

1442 1/2 May

D42936

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42936

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 Elexington ST. 3 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1106 Elexington St.; 1/2 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

A

4-COLOR OR RACE,

N5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Oct 81842

(Month)

(Day)

(Year)

7-AGE,

77 yrs. 6 mos. 38 ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

9-BIRTHPLACE,

(State or Country), Baltimore10-NAME OF FATHER, John P. Lutz

11-BIRTHPLACE OF FATHER

(State or Country), France12-MAIDEN NAME OF MOTHER Dut Korn

13-BIRTHPLACE OF MOTHER

(State or Country), France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert P. Harrison(Address) 1106 Elexington

15-

May 7-1920Robert P. Harrison191 1911 1912 1913 1914 1915 1916 1917 1918 1919 1920 1921 1922 1923 1924 1925 1926 1927 1928 1929 1930 1931 1932 1933 1934 1935 1936 1937 1938 1939 1940 1941 1942 1943 1944 1945 1946 1947 1948 1949 1950 1951 1952 1953 1954 1955 1956 1957 1958 1959 1960 1961 1962 1963 1964 1965 1966 1967 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818 2819 2820 2821 2822 2823 2824 2825 2826 2827 2828 2829 2830 2831 2832 2833 2834 2835 2836 2837 2838 2839 2840 2841 2842 2843 2844 2845 2846 2847 2848 2849 2850 2851 2852 2853 2854 2855 2856 2857 2858 2859 2860 2861 2862 2863 2864 2865 2866 2867 2868 2869 2870 2871 2872 2873 2874 2875 2876 2877 2878 2879 2880 2881 2882 2883 2884 2885 2886 2887 2888 2889 2890 2891 2892 2893 2894 2895 2896 2897 2898 2899 2900 2901 2902 2903 2904 2905 2906 2907 2908 2909 2910 2911 2912 2913 2914 2915 2916 2917 2918 2919 2920 2921 2922 2923 2924 2925 2926 2927 2928 2929 2930 2931 2932 2933 2934 2935 2936 2937 2938 2939 2940 2941 2942 2943 2944 2945 2946 2947 2948 2949 2950 2951 2952 2953 2954 2955

D42932

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42932

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 112 Belvedere ST. 39

WARD)

FULL NAME

Jora B. Guiman

(Residence in Baltimore: No. 112 Belvedere

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH,

Aug

12

1895

(Month)

(Day)

(Year)

7-AGE,

24

9

mos.

25

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,
(State or Country),

Maryland

10-NAME OF FATHER,

Geo. Morningstar

11-BIRTHPLACE OF FATHER
(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Annie Bohre

13-BIRTHPLACE OF MOTHER
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Harvey Bankard

(Address)

Westminster Md.

15-

Filed

Robert B. Harrison,

191

Official Permit to Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, that I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

John Morningstar

(Coroner)

May 7, 1920 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Westminster Md.

19-PLACE OF BURIAL, OR REMOVAL,

Westminster

DATE OF BURIAL,

May 10, 1920

20-UNDERTAKER

H B Bankard & Son

ADDRESS

Westminster Md.

D42938

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42938

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *401 E Cross* ST. *24* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Fannie Kethustine*(a) RESIDENCE. NO. *401 E Cross* ST. WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *25* yrs. mos. ds.How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Thomas Kethustine*6 DATE OF BIRTH (month, day, and year) *Mar 17/1830*

7 AGE

Years *70*Months *1*Days *20*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) *Baltimore Md*10 NAME OF FATHER *Joseph Regus*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*Informant (Address) *Thomas Kethustine 401 E Cross St Baltimore*

1000 Robert F. Harrison

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-7* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from *May 6*, 19*20*, to *May 7*, 19*20*.that I last saw her alive on *May 7*, 19*20*.and that death occurred, on the date stated above, at *8:15 a. m.*

The CAUSE OF DEATH* was as follows:

Coronary of force

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *J. E. Smith*, M. D.17, 19 *20* Address) *910 Regus St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Baltimore Rem 8 May 1920
1100 Back 5028 North Ave

D42939

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42939

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2119 Moyer

ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline May Gregor,

(a) RESIDENCE. No. 2119 Moyer

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 5, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City
(State or country) Md.

10 NAME OF FATHER John Gregor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Anna Popelkova

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bohemia14 Informant Joseph J. Gregor
(Address) 2119 Moyer St.

15 Filed 1920 Robert P. Harrison,

Registrar

Chief Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1920

17 I HEREBY CERTIFY, That I attended deceased from
April 1919, to May 6, 1920,
that I last saw him alive on May 5, 1920,
and that death occurred, on the date stated above, at 7:00 a. m.
The CAUSE OF DEATH* was as follows:

Heart Disease

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. J. Sage, M. D.

. 1920 (Address) 709 N. B. Dwyer

*State the Disease Causing Death, or in deaths from violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Hill Cemetery

May 9, 1920

20 UNDERTAKER

ADDRESS

Wm. C. Black 927 N. Broadway

D42940

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42940

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 S. Gilmer ST.: 19 WARD)REGISTERED NO. 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph T. Robinson Jr.(a) RESIDENCE. No. 126 S. Gilmer ST.: 19 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 1 mos. 14 ds.

How long in U. S., if of foreign birth?

yrs. 1 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male4 COLOR OR RACE white5 Single, Married, Widowed, or Divorced (write the word) single5a If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) Mar 23 1920

7 AGE

Years 1Months 2Days weeksIf LESS than 1 day, hrs. or min. 000

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —(b) General nature of industry, business, or establishment in which employed (or employer) —(c) Name of employer —9 BIRTHPLACE (city or town) (State or country) Ind10 NAME OF FATHER Joe T Robinson11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind12 MAIDEN NAME OF MOTHER Margaret McEntee13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14

15 Burial Permit Clerk, Robert E. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1920

17

I HEREBY CERTIFY, That I attended deceased from May 5, 1920, to May 6, 1920, that I last saw him alive on May 6, 1920.and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Whooping Cough(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.18 Where was disease contracted if not at place of death? unknownDid an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? —(Signed) Dr. Summers, M. D.Address 27 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

CalvertonMay 10 1920

D42941

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42941

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. ST. 12* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Ernest Berling Diddle*(a) RESIDENCE. No. *343 Fourth Ave* ST. *Huntington, W. Va.* WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *1* mos. *2* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *Sept 15-1898*7 AGE *21* Years *7* Months *22* Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Bookkeeper* 008

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Huntington W. Va.* (State or country)10 NAME OF FATHER *James Diddle*11 BIRTHPLACE OF FATHER (city or town) *W. Va.* (State or country)12 MAIDEN NAME OF MOTHER *Mildred Neil*13 BIRTHPLACE OF MOTHER (city or town) *W. Va.* (State or country)14 Informant *Hospital Record* (Address)

ROBERT F. HARRISON,

7 filed 1920 19

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 7* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from *April 5*, 19*20*, to *May 7*, 19*20*, that I last saw him alive on *May 7*, 19*20*, and that death occurred, on the date stated above, at *11:20* a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis, Myocardial Insufficiency, mitral stenosis, Auricular Fibrillation(duration) *1* yrs. *5* mos. ds.CONTRIBUTORY *Pulmonary Infarcts* (Secondary)(duration) yrs. mos. *14* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Dechumacher*, M. D.19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Huntington W. Va.**May 7 1920*

20 UNDERTAKER

ADDRESS

*Joseph Adams**221 N. B. Ave*

D42942

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42942

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1927 Alice Avenue ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1927 Alice Avenue

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE

MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

May 4, 1920

(Month)

(Day)

(Year)

7-AGE,

2 yrs., mos., ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Sherman

11-BIRTHPLACE OF FATHER (State or Country),

Poland

12-MAIDEN NAME OF MOTHER

Agnes Spachke

13-BIRTHPLACE OF MOTHER (State or Country),

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

(Address),

1927 Alice Avenue

Robert P. Harrison,

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 5, 1920

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

May 4, 1920, to May 5, 1920,

that I saw him alive on May 5, 1920,

and that death occurred, on the date stated above, at 8:00 m.

The CAUSE OF DEATH* was as follows:

Traumatic Death

(Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., ds.

(Signed),

May 6, 1920 (Address),

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

May 8, 1920

20-UNDERTAKER

M. F. Sadowski

ADDRESS

705 S. Ann St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42943

D42943

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3712 Green Mt ave* ST.; *12* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Laura E. Burke*(Residence in Baltimore: No. *3712 Green Mt ave* St.; *2* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

*Female*4-COLOR OR RACE, *W*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Widow*
(Write the word.)

6-DATE OF BIRTH,

Oct 27, 1883
(Month) (Day) (Year)

7-AGE,

36 yrs. *6* mos. *7* ds.If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....*Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).....*800*9-BIRTHPLACE,
(State or Country), *Balta CI*10-NAME OF FATHER, *James Bosley*11-BIRTHPLACE OF FATHER
(State or Country), *Ind*12-MAIDEN NAME OF MOTHER *Fannie Crocker*13-BIRTHPLACE OF MOTHER
(State or Country), *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Thos. Sauer*(Address) *3712 Green Mt ave*

15-

*Robert P. Harrison,*Filed *MAY 1912*, 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 6, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 3, 1920*, to *May 6, 1920*, that I saw her alive on *May 15, 1920*, and that death occurred, on the date stated above, at *4:30 a.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration)..... yrs. mos. ds.CONTRIBUTORY
(Secondary)(Duration)..... yrs. mos. ds.
(Signed) *R. P. Mehel* M. D.
May 6, 1920 (Address) *1903 W. North St.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Green Mt

DATE OF BURIAL,

May 8, 1920

20-UNDERTAKER

E. Roy Steffe

ADDRESS

125 E. North ave

Spec. 6-9-15 H. P. Co. - 1000 Bks.
D42944

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42944

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST.: *7th* WARD)

2-FULL NAME

Mrs. Selma Dancy

(a) RESIDENCE. NO.

Bethel North Carolina

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

23

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

*White*5 Single, Married, Widowed,
or Divorced (write the word)*Married*5a If married, widowed, divorced,
or (or) WIFE of*Mrs. W. Dancy*

6 DATE OF BIRTH (month, day, and year)

Dec 26 - 1877

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*42**4**12*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Housewife*(b) General nature of industry,
business, or establishment in
which employed (or employer)*037*

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*North Carolina*

10 NAME OF FATHER

*John Satterwhite*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*North Carolina*

12 MAIDEN NAME OF MOTHER

*Bessie Manning*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*North Carolina*

14

Informant
(Address)*John Records**Robert F. Lafferty*

Filed 1920

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-7-1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 14, 19*20*, to *May 7*, 19*20*.that I last saw her alive on *May 7*, 19*20*.and that death occurred, on the date stated above, at *5:20 a.m.*

The CAUSE OF DEATH* was as follows:

*Carcinoma of Sigmoid.*CONTRIBUTORY
(Secondary)(duration) *2* yrs. mos. ds.*Peritonitis (Postoperative)*

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? *Do not know*Did an operation precede death? *Yes*. Date of *April 26*.Was there an autopsy? *Yes*What test confirmed diagnosis? *X ray*.(Signed) *Dr. John* M. D.19 (Address) *Johns Hopkins Hospital**State the Disease causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Bethel N.C.

DATE OF BURIAL

May 7 1920

20 UNDERTAKER

H. E. Hughes 17 St. Broadway

ADDRESS

D42945

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42945

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *128 N. Anny* ST.; *18* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *128 N. Anny* St.; *24* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

*ae*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

....., *1868*
(Month) (Day) (Year)

7-AGE,

27 yrs. mos. ds.IF LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*House*
*Launders*9-BIRTHPLACE,
(State or Country),*Northumberland Va*

10-NAME OF FATHER,

*unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Northumberland Va*

12-MAIDEN NAME OF MOTHER

*Annie Smith*13-BIRTHPLACE OF MOTHER
(State or Country),*Northumberland Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Smith*(Address) *126 N. Anny*

5- Robert F. Harrison,

8-1920 Burial Permit *Glenn* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 6, 1910
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Feb 28* 191*0*, to *May 6* 191*0*, that I saw her alive on *May 6* 191*0* and that death occurred, on the date stated above, at *345 P* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)(Duration) yrs. mos. ds.
(Signed) *H. P. Haddock* M. D.
16 191*0* (Address) *128 N. Anny*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mela Wharf

DATE OF BURIAL,

May 25, 1910

20-UNDERTAKER

Joseph A. Farrell

ADDRESS

2319 Division

D42946

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42946

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *on Lexington St at Quindley ch.* ST. 18

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Jimm Halliday(Residence in Baltimore: No. *900 Boyd St.* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*Colo S*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Don't know, 1
(Month) (Day) (Year)

7-AGE,

35 yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

Bald m d Chas Halliday

11-BIRTHPLACE OF FATHER (State or Country),

md

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER (State or Country),

C. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henril Easton*(Address) *76 Penn a ave*

15-

*Robert P. Harrison,*Filed *18* 1920

191

Burial Permit Clerk,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 4, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry) had that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Slashed in R. Chest by Hurista Thomas der. from Blumray a few min.
(Duration) yrs. mos. ds.CONTRIBUTORY (Secondary) *as above*

(Duration) yrs. mos. ds.

(Signed) *W. K. Gorman* M. D.
(Coroner.)*May 8, 1920* (Address) *117 W. Saratoga*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*117 W. Saratoga**May 9, 1920*

20-UNDERTAKER

ADDRESS

*Henril Easton**76 Penn a ave*

D42947 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D42942

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Reisterstown Road Near Amos ST. 28 WARD)

REGISTERED NO. 170

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine Hargett

(a) RESIDENCE. No. Reisterstown Rd. Near Amos Ave. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frank C. Hargett

6 DATE OF BIRTH (month, day, and year) Nov. 4, 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). Frederick Co.
(State or country) Maryland.

10 NAME OF FATHER Amos Gosnell

11 BIRTHPLACE OF FATHER (city or town) Carroll Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Ruth Elizabeth Buckingham

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co.
(State or country) Maryland.14 Informant Mrs. Mary A. Gosnell
(Address) Reisterstown Rd. near Amos Ave.

Filed 1920. 19

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1920

17

I HEREBY CERTIFY, That I attended deceased from April 24, 1920, to May 7, 1920, that I last saw her alive on May 6, 1920, and that death occurred, on the date stated above, at 2.40 a.m.

The CAUSE OF DEATH* was as follows:

Eraemic Infection

(duration) yrs. mos. 8 ds.

CONTRIBUTORY Interstitial Nephritis
(Secondary)

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj. F. Phillips M. D.

Address 1929 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Burial Permit Clerk.

May 8 1920

20 UNDERTAKER

ADDRESS

Joseph B. Cook

1003 N. Baltimore St.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D42948

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42948

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 174 Payson

ST. 20 WARD)

2-FULL NAME

Robert E. Greason

(Residence in Baltimore: No. 174 Payson

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH,

May 29, 1874

7-AGE,

45 yrs. 11 mos. 4 ds.

IF LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Tragic Manager
Clothing Factory

9-BIRTHPLACE, (State or Country),

Pennsylvania

10-NAME OF FATHER,

John Greason

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Isabel Kraft

13-BIRTHPLACE OF MOTHER (State or Country),

New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ade Greason

(Address)

174 N. Payson

15-

MAY 8, 1920 Robert F. Harrison,

Regd.

191

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 7, 1920

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

CONTRIBUTORY (Secondary)

Artery (Duration) about 1 mos. ds. Rupture of Coronary Artery (Duration) 2 mos. ds. (Signed) James M. Freeman, M.D. (Coroner) May 9, 1920 (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs.... mos.... ds. In the State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Louisa Park Cem

DATE OF BURIAL,

May 10, 1920

20-UNDERTAKER

Joseph B. Cook

ADDRESS

1003 N. Balto St.

PHYSICIANS should
state statement of
cause of death
may be properly classified. Exact statement of cause of death
point. See instructions on back of certificate.

D42949

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

D42949

PLACE OF DEATH

CITY OF BALTIMORE (No. 2053 Bank

ST: 2 WARD)

2-FULL NAME

Stanley Damesyn

(If death occurred in
a hospital or institution,
give its NAME instead of
street and number and
fill out No. 18.)

(Residence in Baltimore: No. 2053 Bank

St.: yrs. mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

W

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

May

7th, 1920

7-AGE

If LESS than
1 day, 2 hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

9-BIRTHPLACE
(State or country)

Baltimore Md

10-NAME OF
FATHER

Stanley F. Damesyn

11-BIRTHPLACE
OF FATHER
(State or country)

Baltimore Md

12-MAIDEN NAME
OF MOTHER

Mary Wisniewska

13-BIRTHPLACE
OF MOTHER
(State or country)

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

2053 Bank St.

15-

MAY 8 1920

Robert P. Harrison,

Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

7, 1920

17- I HEREBY CERTIFY, That I attended deceased from

May 7, 1920, to, May 7, 1920.

that I saw him alive on May 7, 1920.

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Cyanosis Hematuria

(Duration) yrs. mos. 2 yrs.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

H. P. Tumbleson

M. D.

May 7, 1920 (Address) 2013 Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients,
or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Stanislaus.

DATE OF BURIAL

MAY 8 - 1920

20-UNDERTAKER

M. J. Sadowski

ADDRESS

708 S. Ann St.

PHYSICIANS should
state statement of OCCUPATION
may be properly classified. Exact statement of OCCUPATION
See instructions on back of certificate.

D42950

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D42950

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE

(No. 2053 Bank

ST.

WARD)

2-FULL NAME

Mary Damszyn

(Residence in Baltimore: No.

2053 Bank

Sr.;

yrs.

mos.

ds.)

(If death occurred in
a hospital or institution,
give its NAME instead of
street and number and
fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH

(Month)

(Day)

(Year)

7-AGE

If LESS than

1 day, 12 hrs.

yrs.

mos.

ds.

or min?

8-OCCUPATION

(a) Trade, profession, or
particular kind of work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9-BIRTHPLACE

(State or country)

10-NAME OF
FATHER

11-BIRTHPLACE
OF FATHER
(State or country)

12-MAIDEN NAME
OF MOTHER

13-BIRTHPLACE
OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Robert P. Harrison,

Filed

1920

191

REGISTRAR

Funeral Home

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from

May 7, 1920, to May 7, 1920

that I saw her alive on May 7, 1920,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cyanosis Neonatorum

(Duration)

yrs.

mos.

12 hrs.

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed),

A. L. Trumble

M. D.

May 7, 1920

(Address)

2053 Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients,
or Recent Residents)

At place

of death

Where was disease contracted,

if not at place of death?

Former or

usual residence

In the

State

yrs.

mos.

ds.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Stanislaw.

MAY 8 - 1920

20-UNDERTAKER

M. J. Sadowski.

ADDRESS

705 S. Am.

D42951

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42951

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1007 Plum Alley.

St.: 23 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Ross. (C)

(Residence in Baltimore: No. 1007 Plum Alley.

St.: yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female. 4-COLOR OR RACE, Colored. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widow. (Write the word.)

6-DATE OF BIRTH, Do not know. 1 (Month) (Day) (Year)

7-AGE, 51 yrs. 11 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Calvert Co. Md.

10-NAME OF FATHER, Spriggs. (C)

11-BIRTHPLACE OF FATHER, (State or Country), Calvert Co. Md.

12-MAIDEN NAME OF MOTHER, Rachael II IIII -- (C)

13-BIRTHPLACE OF MOTHER, (State or Country), Calvert Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Ross. (C) son.

(Address) 1006 Plum Alley.

15-

Robert P. Harrison, Registrar.
May 8 1920
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 5th. 1920. 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. M. Pennington M. D.

(Coroner) May 7 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

J. L. Linty May 9 1920

20-UNDERTAKER ADDRESS

John R. Owens 538 W. 2nd St.

D42952

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42952

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

University Hospital ST. 1

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John J. McGarney

(a) RESIDENCE. NO.

927 S. Elwood Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1884

7 AGE

36

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Pat McGarney

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

A. Castell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

PARENTS

14 Informant (Address)

University Data Green & Lombard St.

15 Filed

8 1920

Robert P. Harrison, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-5

1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr 15, 1920, to May 5, 1920,

that I last saw him alive on May 5, 1920,

and that death occurred, on the date stated above, at 6:00 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

CONTRIBUTORY (Secondary)

cachexia

18 Where was disease contracted If not at place of death?

Did an operation precede death? 26. Date of 4/30/20.

Was there an autopsy? 26.

What test confirmed diagnosis? 26.

(Signed) E. Reifschneider, M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Peter

May 10 1920

20 UNDERTAKER

William Cook

ADDRESS

502 E. North Ave

D42953

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D42953

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 633 St. Anne Ave. ST. 9 WARD)

2-FULL NAME

Robert B. Knight

(Residence in Baltimore: No. 633 St. Anne Ave

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Life, mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6-DATE OF BIRTH,

Feb. 14, 1864
(Month) (Day) (Year)

7-AGE,

8-6 yrs. 3 mos. 23 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Carpenter

9-BIRTHPLACE,
(State or Country),

Balt Md

10-NAME OF FATHER,

J. T. Knight

11-BIRTHPLACE OF FATHER
(State or Country),

Balt Md

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER
(State or Country),

" "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Robert C. Knight Jr.

(Address)

633 St. Anne Ave.

15-

Robert P. Harrison,

8 Feb. 1920

191

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 6, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said
(Inquest, au-topsy or inquiry.) and that said deceased came to death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Cyanide Poisoning

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner.)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

Western

DATE OF BURIAL,

May 8, 1920

20-UNDERTAKER

William Cook

ADDRESS

502 S. North Ave.

D42954

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42954

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *216* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Samuel Yarech

(a) RESIDENCE. NO.

201 S. 17th St. Highlandtown Wd.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

+

6 DATE OF BIRTH (month, day, and year)

2, 1906

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

John Yarech

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Horvitzke

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

27th Ave.

15

File

*1920**Robert P. Harrison,*

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-6 1920

17

I HEREBY CERTIFY, That I attended deceased from

*May 5, 1920, to May 6, 1920.*that I last saw him alive on *May 6, 1920.*and that death occurred, on the date stated above, at *5:05 p.m.*

The CAUSE OF DEATH* was as follows:

Acute lobar pneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Laryngeal emphysema (?)

(duration)

yrs.

mos.

3

ds.

18 Where was disease contracted

if not at place of death?

Baltimore

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

Schumacher

M. D.

, 19

(Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Rosary**5/10**1920*

20 UNDERTAKER

ADDRESS

*William Falkner**168**Eastern*

D42955

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42955

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hos* ST.: *3* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Bronislawa Renciewicz(a) RESIDENCE. No. *615 S. Dallas* ST., *3* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? *10* yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept. 1893*

7 AGE

27

Months

7

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Homework.

(b) General nature of industry, business, or establishment in which employed (or employer)

At Home.

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country)

Poland

10 NAME OF FATHER

Charles Lutowski

11 BIRTHPLACE OF FATHER (city or town). (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Alexandra Lutowski

13 BIRTHPLACE OF MOTHER (city or town). (State or country)

Poland

14

Informant (Address)

*Johns Hopkins Records**Robert P. Harrison*

15

Filed

1920

19

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 6* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

April 26, 19 *20*, to *May 6*, 19 *20*,that I last saw *her* alive on *May 6*, 19 *20*,and that death occurred, on the date stated above, at *6:50 P* m.

The CAUSE OF DEATH* was as follows:

Erysipelas(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

Bacterial Endocarditis(duration) yrs. *3* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

J. G. Mateer

M. D.

, 19

(Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Rosary**5/10* 19 *20*

20 UNDERTAKER

William Gialkowski

ADDRESS

Eastern Ave

D42956

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42956

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 Warwick Ave. ST. 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

1718 Warwick Ave.St.; 1 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Oct 5, 1918
(Month) (Day) (Year)

7-AGE,

1 yrs., 7 mos., 0 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),New Jersey

10-NAME OF FATHER,

Horace H. Hale

11-BIRTHPLACE OF FATHER

(State or Country),

Boston

12-MAIDEN NAME OF MOTHER

Lillian E. Lory

13-BIRTHPLACE OF MOTHER

(State or Country),

New Jersey

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Horace H. Hale(Address) 1718 Warwick Ave.

15-

8 1920

Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 6, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 6th 1920, to May 6 1920,that I saw her alive on May 6th 1920,and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Enteritis(Duration) yrs. mos. 2 ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. W. Green

M. D.

May 6, 1920 (Address) 2224 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Woodlawn Cem. May 8, 1920

20-UNDERTAKER

ADDRESS

For funeral services 207 S. Pine

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42957

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Johns Hopkins Hospital

CITY OF BALTIMORE: (No.

North Broadway

ST.: 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary B. Coyle

(Residence in Baltimore: No.

1317 N. Charles St.

St.: 20 yrs., -- mos. -- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

July

26

1846

(Month)

(Day)

(Year)

7-AGE,

73

9

11

ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country),

Rochester, New York

10-NAME OF FATHER,

Thomas J. Kernan

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Mary Ann Lennon

13-BIRTHPLACE OF MOTHER

(State or Country),

Rochester, New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Mrs. Katharine J. Howard

(Address).....1317 N. Charles Street...

15-

Robert P. Harrison,

8-1920

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

7

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr 26 1920, to May 7 1920,

that I saw him alive on May 7 1920,

and that death occurred, on the date stated above, at 12:15 p.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Arterio-sclerosis and

hypertension

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY

(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

May 7....., 1920 (Address).....Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 11 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? home

Former or usual residence 1317 N. Charles St. Baltimore

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery

DATE OF BURIAL,

5/10....., 1920.

20-UNDERTAKER

Henry W. Nears & Son 805 N. Calvert St.

D42958

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42958

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Russell + Annapolis Ave* ST.; *25* WARD)2-FULL NAME *Ludwig Nagel (Nagel)*(Residence in Baltimore: No. *Russell + Mt Vernon* St.; *45* yrs., *6* mos., *20* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *m*4-COLOR OR RACE, *w*5-SINGLE, ☒ MARRIED, ☒ WIDOWED, ☒ OR DIVORCED, ☐
(Write the word.)6-DATE OF BIRTH, *10* *16*, *1852*

(Month)

(Day)

(Year)

7-AGE, *67* yrs., *6* mos., *20* ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Laborer in*(b) General nature of industry, business, or establishment in which employed (or employer), *Glass works*9-BIRTHPLACE, (State or Country), *Germany*10-NAME OF FATHER, *unknown*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER, *unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

PARENTS.

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary E. Nagel*(Address) *Russell St. + Annapolis Ave*

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *5* *6*, *1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Nov 19* 1919, to *May 5* 1920,that I saw him alive on *May 5* 1920,and that death occurred, on the date stated above, at *3:15 a.m.*

The CAUSE OF DEATH* was as follows:

corner of stomach

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY..... *exhaustion*
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... *Thos B. Hall* M. D.*5-4-20*, 1920 (Address) *Halethorpe*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Western Bur.*DATE OF BURIAL, *May 8, 1920*20-UNDERTAKER, *Philip Herwig*ADDRESS *2016 Orleans*

D42959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42959

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

2512 E. Baltimore

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Flamm

(a) RESIDENCE. NO.

2512 E Baltimore

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

68 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

68 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widower

5a If married, widowed, or divorced

HUSBAND of

Catherine Flamm

6 DATE OF BIRTH (month, day, and year)

March 25th 1885

7 AGE

Years

85

Months

1

Days

12

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country)

Germany

10 NAME OF FATHER

George Flamm

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14 Informant

(Address)

George L. Flamm
2512 E Baltimore St

Filed

Robert L. [unclear],
19

Registrar

1920

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 7th 1920

17

I HEREBY CERTIFY, That I attended deceased from

May - 1918, to May 7, 1920.

that I last saw him alive on, 19.

and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Anterior
Embolism - Sclerotic
& Lungs - Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Enlarged Prostate
& Cystitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Albert C. [unclear] M. D.

, 19 (Address)

1303 N. [unclear]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

May 10th 1920

20 UNDERTAKER

ADDRESS

George Schilling & Sons

1126 E. [unclear]

D42960

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42960

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 17)

2-FULL NAME

(Residence in Baltimore: No. 2111 Guilford Ave.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Married

6-DATE OF BIRTH

May

23

1887

(Month)

(Day)

(Year)

7-AGE,

62

YRS. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Retired Radio Merchant

9-BIRTHPLACE, (State or Country).

New York

10-NAME OF FATHER,

Isiah Morris

11-BIRTHPLACE OF FATHER (State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Yetta Levin

13-BIRTHPLACE OF MOTHER (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joseph Morris

(Address)

2111 Guilford Ave.

15-

Robert P. Harrison,

Yrs. 1920

191

Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

May

6

1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

Inquest, autopsy or inquiry

thereon and from the evidence obtained by said

Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Tubercular disease of heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

John Harrison

(Address)

7632 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

A. Heb Sholon

DATE OF BURIAL,

May 9, 1920

20-UNDERTAKER

Joseph Abene

ADDRESS,

1611 Madison Ave.

D42961

CITY OF BALTIMORE: (NO. St Joseph Hosp. ST. 26 WARD)

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(b) RESIDENCE. NO. 2802 Rockdale Ave Ward 12 WARD. (If not)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE white	5 Single, Married, Widowed, or Divorced (write the word) Married
-----------------	--------------------------	--

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of *Wife of David*

6 DATE OF BIRTH (month, day, and year) July 21 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... *at Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town).....
(State or country) *Germany*

10 NAME OF FATHER Booth

11 BIRTHPLACE OF FATHER (city or town).....
(State or country) *Germany*

12 MAIDEN NAME OF MOTHER *not known*

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) *Germany*

14 Informant David Eugene Kover
(Address) Robert A. Kover 1924

18 1920

19
Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1968 ✓ 19 68

17 I HEREBY CERTIFY, That I attended deceased from
April 15, 1928, to May 8, 1928,
that I last saw her alive on May 8, 1928,
and that death occurred, on the date stated above, at 3.00 a.m.

The CAUSE OF DEATH* was as follows:

Why so sudden
somehow

CONTRIBUTORY *Structural Steel*
(Secondary)
(duration) *2* yrs. mos. ds.

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death? 428 Date of April 20-1980

Was there an autopsy? NO

What test confirmed diagnosis? Specimen
(Signed) S. F. Baker, M. D.

. 19 (Address) *St Josephs Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

<u>19 PLACE OF BURIAL, CREMATION OR REMOVAL</u>	<u>DATE OF BURIAL</u>
--	------------------------------

Balto Cemetery May 10 19

20 UNDERTAKER	ADDRESS
Louis's Heermann	325 Broadway

HEALTH DEPARTMENT--CITY OF BALTIMORE

1042962

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. 12962)

2-FULL NAME

(Residence in Baltimore: No. 942 U. Bedford

REGISTERED No. C

WARD

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 2 yrs. ? mos. ? ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

MAY 8 1920

Robert P. Harrison

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

April 26, 1920, to May 7, 1920

that I saw her alive on May 7, 1920

and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Diphtheria, tonsillitis

(Duration) — yrs. — mos. 13 ds

Contributory (SECONDARY)

acute ileocolitis

(Duration) — yrs. — mos. 8 ds

(Signed)

May 8, 1920 (Address) Sydenham Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. 12 ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Vincent's Cem

May 8, 1920

20-UNDERTAKER

ADDRESS

David Sondheim 118 W. Mt Royal Ave

D42963

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42963

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 2111 Etlings

St. 14

WARD)

2-FULL NAME

Molly Beatrice Moses

(Residence in Baltimore: No. 2111 Etlings St.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH,

April 27, 1920

(Month) (Day) (Year)

7-AGE,

yrs. mos. 11 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

unemployed

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

10-NAME OF FATHER,

William Moses

11-BIRTHPLACE OF FATHER (State or Country),

Virginia

12-MAIDEN NAME OF MOTHER,

Clara Ayers

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Clara Moses

(Address)

2111 Etlings St.

MAY 9 - 1920

Filed

101

ROBERT B. KAUTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 7, 1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.) inquiry

thereon and from the evidence obtained by said

(Inquest, au- inquiry)

and that said deceased came to death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Faded heart failure

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

Cardiac insufficiency

(Duration) yrs. mos. 11 ds.

(Signed)

J. A. Hennessy

(Coroner.)

May 7, 1920 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt. Zion Cemetery

May 8, 1920

20-UNDERTAKER

ADDRESS

Mrs. R. A. Elliott

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42964

CERTIFICATE OF DEATH.

151 D42964

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4115 Register

ST.: 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Malagarska (WALIGORSKA)

(a) RESIDENCE. NO.

411 S. Register

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

April 24

7 AGE

Years

Months

Days

If LESS than 1 day, ____ hrs. or ____ min.

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

"

(c) Name of employer

"

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Stefan Maligorski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Petronella Krup

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Stefan Maligorski 411 S. Register

15

MAY 9-1920

ROBERT E. KRAUTER

Registrar

Bacial Health Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-7 1920

17

I HEREBY CERTIFY, That I attended deceased from 4-25, 1920, to 5-7, 1920,

that I last saw him alive on 5-7, 1920,

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Residence

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptom & signs

(Signed) W. A. Antelope, M. D.

5-7, 1920 (Address) 1023 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus

5/9 1920

20 UNDERTAKER

William Fialkowski

ADDRESS

A17

D42965

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42965

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Greenspring*)ST. *97*

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Hattie L. Sawyer(Residence in Baltimore: No. *Greenspring*)St.; yrs., mos. *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

F.

4-COLOR OR RACE,

C.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

*May**6*

(Day)

1920

(Year)

7-AGE,

6

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Balt city Ind

10-NAME OF FATHER,

Louise Sawyer

11-BIRTHPLACE OF FATHER (State or Country),

Balt

12-MAIDEN NAME OF MOTHER

Helon Wilson

13-BIRTHPLACE OF MOTHER (State or Country),

Balt Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Helon Sawyer

(Address)

Greenspring

15-

MAY 9-1920

ROBERT H. KRAUTER

Filed

101

OFFICIAL FORM

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*May**6*

(Day)

1920

(Year)

17- I HEREBY CERTIFY, That I took charge of the

remains described above, held an.....
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....
(Inquest, au-topsy or inquiry.....
on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

John J. Harrison

(Coroner.)

May 8 1920 Address *1632 Rolfe*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Greenbury**May 9, 1920*

20-UNDERTAKER

ADDRESS

Sam L. Hemmels, 78 W. Biddle

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42966

CERTIFICATE OF DEATH.

78

D42966

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2440 M. Cullogh

ST. 13

WARD)

2-FULL NAME

Rose Cohen

(Residence in Baltimore: No. 2440 M. Cullogh

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 21 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

October 29, 1899

7-AGE,

21 yrs. 6 mos. 7 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Clerk
(b) General nature of industry, business, or establishment in which employed (or employer). Tailoring

9-BIRTHPLACE, (State or Country),

Baltimore, Md

10-NAME OF FATHER,

Isaac Cohen

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Rosa Harris

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Isaac Cohen (father)

(Address)

2440 M. Cullogh

MAY 9 - 1920

ROBERT E. BAUTER

Filed 191

BALTIMORE HEALTH DEPARTMENT

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 7, 1920

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, au-

quity and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Edema of lungs

(Duration) yrs. mos. ds.

(Signed)

J. D. Hennessy M. D.

(Coroner.)

May 8, 1920 (Address) 2802 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew Burial Society

May 9, 1920

20-UNDERTAKER

ADDRESS

Jack Lewis

1411 E. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42967

D42967

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hehren aged home* ST.; *5* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *115 Airs Guntz St.* ST. *5* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *3* yrs. *6* mos. ds.How long in U. S., if of foreign birth? *37* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

*Widower*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of *Unknown*6 DATE OF BIRTH (month, day, and year) *Unknown 1846*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*74*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Russia*

10 NAME OF FATHER

Mordica Gribon

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant
(Address)*J. H. H. 1411 E. Balt St.*

15

MAY 9 - 1920

ROBERT A. KEEUTER

Serial Permit 0107

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/9* 1920

17

I HEREBY CERTIFY, That I attended deceased from
May 7, 19*20*, to *May 8*, 19*20*,
that I last saw him alive on *May 8*, 19*20*,
and that death occurred, on the date stated above, at *4 A* m.
The CAUSE OF DEATH* was as follows:*Acute Cordiac dilatation*CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

Natural insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?*not known*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *physical*

(Signed)

7/9, 1920 (Address)*Dr. J. B. Bayne, M. D.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Hehren Rosedale**5/9* 1920

20 UNDERTAKER

ADDRESS

*Jack Lewis**1411 E. Balt St.*

Louis Citrone ✓
HEALTH DEPARTMENT—CITY OF BALTIMORE

D42968

D42968

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *114 Lloyd*)St.: *3* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *114 Lloyd*)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

m

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

May 15, 19*19*.
(Month) (Day) (Year)

7-AGE,

9 yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work,
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),*Belle*

10-NAME OF FATHER,

Carl Citrone

11-BIRTHPLACE OF FATHER

(State or Country),

Ill

12-MAIDEN NAME OF MOTHER

May Citrone

13-BIRTHPLACE OF MOTHER

(State or Country),

Ill

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Louis Citrone*(Address) *114 Lloyd*

ROBERT E. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 8, 19*20*.
(Month) (Day) (Year)

17-HEREBY CERTIFY, That I attended deceased from

May 6, 19*20*, to *May 8*, 19*20*,

that I saw h. alive on *May 8*, 19*20*,and that death occurred, on the date stated above, at *11* m.

The CAUSE OF DEATH* was as follows:

Bronch. Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. Valentin* M. D.

Bldg. 101, 19*20*. (Address) *165 1/2 W. 7*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Vincent**May 9*, 19*20*.

20-UNDERTAKER

ADDRESS

*Wendell Dappel & Son**378 N. Ave.*

MAY 9 - 1920
101
BUTLER STREET

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42969

D42969

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

1 SEX

4 COLOR OR RACE

5 Single. Married. Widowed.
or Divorced (write the word)6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

MAY 9 - 1920

ROBERT H. BAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1920

17

I HEREBY CERTIFY, That I attended deceased from
April 15, 1920, to May 7, 1920,
that I last saw her alive on May 7, 1920,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

CONTRIBUTORY (Secondary)
(duration) yrs. 1 mos. 1 ds.
Metral Insufficiency18 Where was disease contracted
if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? physical signs & symptoms

(Signed) Daniel Miller, M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

9 May 1920

20 UNDERTAKER

ADDRESS

Wm. D. Sygel & Son

378 Ann

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42970

CERTIFICATE OF DEATH.

42 D42970

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3402 Mt Pleasant Ave ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 3402 Mt Pleasant Ave WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of George H Beauchamp
(or) WIFE of Widow of George H Beauchamp6 DATE OF BIRTH (month, day, and year) Sept 28 - 18557 AGE Years 64 Months 7 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)10 NAME OF FATHER Elijah Lambert11 BIRTHPLACE OF FATHER (city or town) Balt
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Balt
(State or country)14 Informant Mr. Harry Carme
(Address) 3402 Mt Pleasant Ave15 MAY 9 - 1920 ROBERT I. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 19 2017 I HEREBY CERTIFY, That I attended deceased from Oct. —, 19 19, to May 8, 19 20,
that I last saw her alive on May 7, 19 20,
and that death occurred, on the date stated above, at 12 32 a.m.
The CAUSE OF DEATH* was as follows:Carcinoma uteri

(duration) ? yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ?
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Allen C. Beetham, M. D.5-8, 19 20 Address 3139 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Christ Church May 12 19 20

20 UNDERTAKER ADDRESS

Wm. Cook 502 E. North Ave

See instructions on back of certificates. Property classified. Exact statement of O.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42971

CERTIFICATE OF DEATH.

100 D42971

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

603 S. Glover

ST.;

WARD)

2-FULL NAME

Annie Jemzykowski

(Residence in Baltimore: No.

603 S. Glover

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

S

6-DATE OF BIRTH,

May

1

1914

(Month)

(Day)

(Year)

7-AGE,

4

mos.

7

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore Md

10-NAME OF FATHER,

John Jemzykowski

11-BIRTHPLACE OF FATHER, (State or Country),

Poland

12-MAIDEN NAME OF MOTHER

Anne Kozin

13-BIRTHPLACE OF MOTHER, (State or Country),

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Jemzykowski

(Address)

603 S. Glover

15-

MAY 9 - 1920

ROBERT T. FRATES

Filed

191

Burial Place

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

8

1914

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from May 5 1914, to May 8 1914, that I saw her alive on May 8 1914, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Retropharyngeal abscess

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Rosema

(Duration) ... yrs. ... mos. ... ds.

(Signed)

H. Frankenburg M. D.

May 8, 1914 (Address) 2471 East

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Rosary Bur May 10, 1920

20-UNDERTAKER

ADDRESS

Stephen P. Galkowski 100 S. Howard

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42972

CERTIFICATE OF DEATH.

D42972

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bernard Ave. 25* ST. *25* WARD)2-FULL NAME *Margaret Ellen Reily*(a) RESIDENCE. No. *Bernard Ave. 25* ST. *25* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *5 yrs.* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F.* 4 COLOR OR RACE *W.* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Adeline Reily*6 DATE OF BIRTH (month, day, and year) *Dec 29 / 1850*7 AGE Years *69* Months *4* Days *9* If LESS than day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Ernest Morris*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Elizabeth Carndine*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*Informant (Address) *M. Reily*

MAY 9 - 1920

ROBERT B. ERSTLER

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 5* 19*20*17 I HEREBY CERTIFY, That I attended deceased from *May 1*, 19*20*, to *May 8*, 19*20*.that I last saw her alive on *May 7*, 19*20*.and that death occurred, on the date stated above, at *6 A* m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(duration) yrs. *3* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *5* ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Geo. S. Kieffer*, M. D.May 8 1920 (Address) *Monroe Park*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Land on Park**May 8 / 1920*

20 UNDERTAKER

ADDRESS

*J. M. Cook**St. Louis*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42973

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 131/3 Olden Ave. ST., 13 WARD.
(Usual place of abode) (If none, state where born)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? 37 yrs. — mos. — ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1934

17 I HEREBY CERTIFY, That I attended deceased from
Mar 20 1920 to May 8 1920
that I last saw h. w. alive on May 8 1920
and that death occurred, on the date stated above, at 11 N. F. m.
The CAUSE OF DEATH* was as follows:

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) — yrs. 1 mos. 8 ds

CONTRIBUTORY
(Secondary)

(duration) yrs. mo. da.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Yes Date of _____

Was there an autopsy? Yes

What test confirmed diagnosis?.....
(Signed) M. A. Fair, M. D.

12 E 25th

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Mary's Hampden May 11 192

20 UNDERTAKER ADDRESS

ROBERT E. KRAUTER
Special Permit Registrant

20 UNDERTAKER ADDRESS

Norace *Quercus* *montana* 363/4allo.

Exact statement of OCCUPATION is required.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42974

64

D42974

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.:

WARD)

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 17 yrs., - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

6-DATE OF BIRTH,

7-AGE,

IF LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAY 9 - 1920

191

ROBERT E. KRAUTER

Barial Permit (No. 1000)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, an-

find that said deceased came to death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.....mos.....ds. In the State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

D42975 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1301 Light ST.; 24 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 1301 Light ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed or Divorced (write the word) Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of William Damm

6 DATE OF BIRTH (month, day, and year) March 12/1849

7 AGE Years 71 Months 1 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md

10 NAME OF FATHER Henry Trumbo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Maria Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md

14 Informant (Address) William Damm 1301 Light St

15 MAY 9-1920 DECEASED BY TRAUMA Burial Permit 0124

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1920

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1920, to May 8, 1920,

that I last saw him alive on May 8, 1920,

and that death occurred, on the date stated above, at 11:55 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

CONTRIBUTORY (Secondary) Dilated heart (duration) 3 mos. ds.

18 Where was disease contracted (duration) yrs. mos. ds.

If not at place of death? he had been

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) A. H. H. M. D.

19 (Address) 1340 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Western Cemetery 5/11/20

20 UNDERTAKER ADDRESS

William Cook 506 North

D42976

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92-119 D42976

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 S. Curley ST. 1 WARD)

2-FULL NAME

Mary Baker

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

910 S CurleyST. 1 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Married</u>
------------------------	---------------------------------	--

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Baker6 DATE OF BIRTH (month, day, and year) July 12, 18867 AGE Years 33 Months 9 Days 25 If LESS than 1 day, hrs. — or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

10 NAME OF FATHER

Not Known

11 BIRTHPLACE OF FATHER (city or town)

Poland

(State or country)

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town)

Poland

(State or country)

14

Informant

(Address)

J. Baker
910 S Curley St

15

MAY 9 - 1920

ROBERT K. KRAUTER
Registrar

Serial permit 0123

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 15, 1920, to May 7, 1920,that I last saw her alive on May 7, 1920,and that death occurred, on the date stated above, at 1:30 P.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis(duration) yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary)

Labar Pneumonia(duration) yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Observation(Signed) H. B. Tillow, M. D.Address 2921 Odumell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus CemMay 10 1920

20 UNDERTAKER

Stephen J. Fialkowski

ADDRESS

1100 S. Kurood

66 D42972

REGISTERED No. C

CITY OF BALTIMORE: (No

ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. ds.

MEDICAL CERTIFICATE OF DEATH.

3-SEX.

4-COLOR OR RACE.

5-SINGER, *hail*
MARRIED,
WIDOWED,
OR-DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

....., 1850
(Month) (Day) (Year)

7-AGE.

70. Tra... nion... du.

It LESS than 1 day.

....hrs. or....min.?

S-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

D-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER.

**11-BIRTHPLACE
OF FATHER
(State or Country).**

12-MAIDEN NAME
OF MOTHER

**13-BIRTHPLACE
OF MOTHER
(State or Country).**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address

16-DATE OF DEATH.

5 7, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
 May 12 1920, to May 6 1920,
 that I saw him alive on May 6 1920,
 and that death occurred, on the date stated above, at 3 E. m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Duration) months days
(Signed) *P. G. and M. D.* M. D.
May 10 1920 (Address) *1534 5th Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.mo.da. In the State.....yrs.mo.da.

Where was disease contracted,
if not at place of death?.....

Former or
usual residence

10-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

15- MAY 9 - 1920 ROBERT V. KRAUTER
101... BIRTH... REGISTRAR.

D42978

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

37 D42978

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital.ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Holloway(a) RESIDENCE. No. 716 W. Sterling St.
(Usual place of abode)

ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds.How long in U. S., if of foreign birth? 4 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of Lillian Holloway
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18967 AGE Years 24 Months 5 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) South Carolina
(State or country)10 NAME OF FATHER Jim Merry11 BIRTHPLACE OF FATHER (city or town) S. Carolina
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) S. Carolina
(State or country)14 Informant Hospital Records(Address) New City Hospital15 Filed MAY 9-1920 ROBERT H. KRAUTER Registrar
BRIAL Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1920

17

I HEREBY CERTIFY, That I attended deceased from February 13, 1920 to May 7, 1920, that I last saw her alive on May 7, 1920, and that death occurred, on the date stated above, at 9:55 P. m.

The CAUSE OF DEATH* was as follows:

Acute embolism, secondary infected producing general toxemia.(duration) yrs. 9 mos. ds.CONTRIBUTORY (Secondary) Syphilis(duration) yrs. unknown mos. ds.18 Where was disease contracted if not at place of death? noDid an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? none(Signed) Frank T. Barber, M. D.May 8, 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Marion S. C.May 8, 1920

20 UNDERTAKER

ADDRESS 725Mrs Rolt a ElliottAnnapolis

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42979

D42979

CERTIFICATE OF DEATH.

55

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1403 S. Charles ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1403 S. Charles St.; 12 yrs., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH.

April 30, 1908
(Month) (Day) (Year)

7-AGE,

12

yrs. mos. 7 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Balto., Md.

10-NAME OF FATHER,

John Hubbschman Sr.

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Regina Scherive

13-BIRTHPLACE OF MOTHER
(State or Country),

Philadelphia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Hubbschman
1403 S. Charles St.

(Address)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 7, 1920
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from May 2, 1920, to May 6th, 1920, that I saw him alive on May 6th, 1920, and that death occurred, on the date stated above, at 7¹¹ m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. J. Carver M. D.

May 7, 1920 (Address) 412 N. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Holy Cross Cem. & Co.

DATE OF BURIAL.

May 10, 1920

20-UNDERTAKER

McG. Flynn

ADDRESS

1422 Light

MAY 9 - 1920

ROBERT H. TRAUTER

Burial Place Registered

D42980

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50 D42980

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *12th Battery Ave* ST.: *24* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

James Jenkins

(a) RESIDENCE

No. 12th Battery Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

73 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

43 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 1, 1847

7 AGE

73 Years

Months

4

Days

6

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

Ship Caulker.

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Ship Board

(c) Name of employer

No regular place.

9 BIRTHPLACE (city or town) (State or country)

Baltimore.

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

John Jenkins 12th Battery Ave

15

MAY 9-1920

ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 7 1920

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 11- 1920, to May 7 1920*that I last saw him alive on *May 7 1920*and that death occurred, on the date stated above, at *11 a. m.*

The CAUSE OF DEATH* was as follows:

Leukemia

CONTRIBUTORY (Secondary)

(duration) *1* yrs. *0* mos. *0* ds.(duration) *0* yrs. *0* mos. *0* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Microscopic Analysis*(Signed) *C. M. White* M. D.May 8, 1920 (Address) *299 William St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Olivet Cem; May 10 1920

20 UNDERTAKER

ADDRESS

M. G. Flynn 1422 Light

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42981

D42981

1-PLACE OF DEATH

Johns Hopkins Hospital

CITY OF BALTIMORE: (No.)

North Broadway

ST.; 14 WARD)

2-FULL NAME

Lindley E. Scarlett

(Residence in Baltimore: No.)

1717 Bolton Street

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, *single*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Oct 2, 1870
(Month) (Day) (Year)

7-AGE,

49 yrs. 7 mos. 7 ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Detective

(b) General nature of industry, business, or establishment in which employed (or employer).

071

9-BIRTHPLACE,

(State or Country),

Indiana

10-NAME OF FATHER,

W. W. Scarlett

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Madeline Hider

13-BIRTHPLACE OF MOTHER

(State or Country),

N. J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Records of the

(Address).....

Johns Hopkins Hospital

F. E. RAUTER

Filed MAY 10 1920

MAY 10 1920

Registrar.

E. H. J.

Watchman

MEDICAL CERTIFICATE OF DEATH.

15-DATE OF DEATH,

May 9, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Feb. 16 1920, to May 9 1920,

that I saw him alive on May 9, 1920,

and that death occurred, on the date stated above, at 4:37 A. M.

The CAUSE OF DEATH* was as follows:

Fracture of cervical vertebra with
injury to cervical cord - Patient
threw himself down marble stairs
in attempt at suicide

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY

(Secondary)

Psychosis (mental depression)
(Duration).....yrs.....mos.....ds.

(Signed).....

Augusta Scott

M. D.

May 9, 1920. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. 2 mos. 22 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

1717 Bolton Street

17-PLACE OF BURIAL OR REMOVAL,

Blackwood VJ

DATE OF BURIAL,

May 13, 1920

18-UNDERTAKER,

J. J. Quinn & Co.

ADDRESS

22 N. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42982

CERTIFICATE OF DEATH.

D42982

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *412 W Ostend* ST.; *21* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *412 W Ostend* ST.; *63* yrs., *2* mos., *26* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: *Female*
 4-COLOR OR RACE: *White*
 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*
 6-DATE OF BIRTH, *Feb 10* *1857*
 (Month) (Day) (Year)

7-AGE, *63* *2* *26*
 yrs. mos. ds.
 IF LESS than 1 day, hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work..... *Store Keeper*
 (b) General nature of industry, business, or establishment in which employed (or employer)..... *Grocery Store*

9-BIRTHPLACE, (State or Country), *Baltimore, Md.*

10-NAME OF FATHER, *Michael Getzer*
 11-BIRTHPLACE OF FATHER (State or Country), *France*
 12-MAIDEN NAME OF MOTHER, *Mary Heidlach*
 13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edward Mertz*
 (Address) *412 W Ostend St.*

15- *MAY 10 1920* *ROBERT E. KRAUTER*
 Burial Permit No. *101*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 6th*, *1920*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 3* *1920*, to *May 6* *1920*, that I saw him alive on *May 6* *1920*, and that death occurred, on the date stated above, at *11:45* a.m.

The CAUSE OF DEATH* was as follows:
Pneumonia
Infant
 (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) *Pneumonia*
 (Duration)..... yrs..... mos..... ds.

(Signed) *Edw. Mertz* M. D.
May 8, *1920* (Address) *30 Light St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Linden Park* DATE OF BURIAL, *May 10, 1920*

20-UNDERTAKER, *Mr. John W. Poyel* ADDRESS, *801 W. Fayette*

D42983

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D42983

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *748 W. Mulberry* ST.: *17* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. *George Nelson*(a) RESIDENCE. NO. *748 W. Mulberry* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *6* yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col.

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1867*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Howard House*9 BIRTHPLACE (city or town) (State or country) *Va*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown Va*12 MAIDEN NAME OF MOTHER *Nancy Nelson*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Richmond Va*

14

Informant (Address) *Nannie Nelson 748 W. Mulberry St*

15

MAY 10 1920

ROBERT E. LAUTER Registrar

Burial Permit 0102

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 8 1920*

17

I HEREBY CERTIFY, That I attended deceased from *May 3rd*, 19*20*, to *May 8th*, 19*20*, that I last saw him alive on *May 8th*, 19*20*, and that death occurred, on the date stated above, at *12 A* m. The CAUSE OF DEATH* was as follows:*Left Pneumonia*(duration) yrs. mos. *6* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Wm G. Threl* M. D.5/8, 1920 (Address) *206 N. Fulton Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Doswell Va**May 10 1920*

20 UNDERTAKER

Daniel E. Egan

See instructions on back of certificates. Exact statement of OCCUPA-

1. The statement of the informant should state the name of the informant. Exact statement of OCCUPATION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42984

CERTIFICATE OF DEATH.

105
D42984

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

St.

WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St. 8 yrs., 1 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,
... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAY 10 1920

ROBERT E. KRAUTER

Reg. No.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*
(Inquest, au-

quary and that said deceased came to death
(autopsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. C. Hennessy* M. D.
(Coroner.)

May 7, 1920 (Address) *2802 Edmondson Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

D42985

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D42985

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Pinkett(a) RESIDENCE. No. Unknown

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>Black</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Married</u>
----------------------	---------------------------------	--

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of
Unknown6 DATE OF BIRTH (month, day, and year) 1855

7 AGE <u>65</u>	Years	Months	Days	If LESS than 1 day, hrs. or min.
--------------------	-------	--------	------	--

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)14 Informant Hospital Records(Address) New City Hospital.15 MAY 10 1920 ROBERT A. TRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1920

17 I HEREBY CERTIFY, That I attended deceased from
April 24, 1920, to May 5, 1920,
that I last saw him alive on May 5, 1920,
and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis &
HypertensionUnknown (duration) yrs. mos. ds.CONTRIBUTORY Hemiplegia; Cerebral
(Secondary)
Hæmorrhage (duration) yrs. 2 mos. ds.18 Where was disease contracted Unknown
if not at place of death?Did an operation precede death? no Date of yesWas there an autopsy? yesWhat test confirmed diagnosis? hospital test(Signed) J. F. Pessel, M. D.May 5, 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Asbury CemeteryMAY 10 1920

20 UNDERTAKER

ADDRESS

R. B. Gross 1405 McElderry StSee instructions on back of certificates. Exact statement of OCCUPA-
tion should be properly classified.

D42986

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42986

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 543 N. Hoffman ST.: 17 WARD)2-FULL NAME Sarah Peaco(a) RESIDENCE. No. 543 N. Hoffman ST.: 17 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 5 mos. 5 ds. How long in U. S., if of foreign birth? 50 yrs. 5 mos. 5 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Caucasian 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced Widowed of (or) WIFE of James Peaco.6 DATE OF BIRTH (month, day, and year) Unknown 18617 AGE Years 59 Months — Days — If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General house work(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond, Va. (State or country)10 NAME OF FATHER Joe. Gilpin11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)12 MAIDEN NAME OF MOTHER Mathias DeBretteville13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)14 Informant Reson Key (Address) 543 N. Hoffman St.5 Filed MAY 10 1920 ROBERT E. FRATER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/7/192017 I HEREBY CERTIFY, That I attended deceased from Mar 14, 1920, to May 7, 1920, that I last saw her alive on May 6, 1920, and that death occurred, on the date stated above, at 11:25 a.m. The CAUSE OF DEATH* was as follows:Uremia(duration) 2 yrs. 2 mos. 2 ds.CONTRIBUTORY General hemorrhages (Secondary) Paralysis (duration) 2 yrs. 2 mos. 4 ds.18 Where was disease contracted if not at place of death? —Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? Physical(Signed) Dr. H. Tompkins, M. D.Address 1019 S. Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cen. DATE OF BURIAL May 10 192020 UNDERTAKER Sam'l Hensley ADDRESS 5/8 Hill

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42987

D42987

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

633 N. Carrollton Ave. 16

WARD)

2-FULL NAME

John. Laird Bedsworth.

(a) RESIDENCE. NO.

633 N. Carrollton Ave.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 16, 1912

7 AGE

Years

Months

Days

If LESS than
1 day,.....hrs.
or.....min.

7

7

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

School Boy

(b) General nature of industry,
business, or establishment in
which employed (or employer)

ood

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Maryland.

10 NAME OF FATHER

John. Thos. Bedsworth

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Daisy E. Laird

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Maryland

14

Informant

(Address)

John. Thos. Bedsworth.

633 N. Carrollton Ave.

15

MAY 10 1920

ROBERT A. LAUTER
Registrar

Baltimore City

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 9th 1920

17

I HEREBY CERTIFY That I attended deceased from

May 6th 1920 to May 9th 1920

that I last saw him alive on May 9th 1920

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard J. Leback M. D.

9, 1920 (Address) 633 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Crisfield Md.

5-10th 1920

20 UNDERTAKER

ADDRESS

A Rohde & Son.

600 N. Holliday Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42988

CERTIFICATE OF DEATH.

55 D42988

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *New City Hospital* ST.: *26* WARD)

2-FULL NAME

(a) RESIDENCE

(Usual place of abode)

Length of residence in city or town where death occurred

47 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mrs. C. J. Kneavel

6 DATE OF BIRTH (month, day, and year)

Jan. 6 1872

7 AGE

48

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Policeman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt. Md.

10 NAME OF FATHER

Matthews Kneavel

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balt. Md.

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

*Hospital Records
New City Hospital*

15

Filed

MAY 10 1920

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-8 1920

17

I HEREBY CERTIFY, That I attended deceased from

4-14, 19 *20*, to *5-8*, 19 *20*,that I last saw him alive on *5-8*, 19 *20*,and that death occurred, on the date stated above, at *11 30* A.M.

The CAUSE OF DEATH* was as follows:

Septicemic Encephalitis(duration) yrs. *17* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

City

Did an operation precede death?

Date of

Was there an autopsy?

yes

What test confirmed diagnosis?

no special tests

(Signed)

J. J. Kneavel

M. D.

5-8, 1920 (Address)

Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Church**May 12 1920*

20 UNDERTAKER

Henry Jones, Son

ADDRESS

1201 E. Eager St.

Exact statement of OCCUPA-

Instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42989

CERTIFICATE OF DEATH.

80

D42989

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1605 N. Bradford* ST.: *8* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *1605 N. Bradford* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *38* yrs. *1* mos. *1* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of *Julia Berlad Berlach*
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Not known*

7 AGE

38

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

East worker for 086

(b) General nature of industry, business, or establishment in which employed (or employer)

Fleischman Co.

(c) Name of employer

9 BIRTHPLACE (city or town) *Balt.*
(State or country)10 NAME OF FATHER *Friedrich Berlach*11 BIRTHPLACE OF FATHER (city or town) *Germany*
(State or country)12 MAIDEN NAME OF MOTHER *Mary Heitzel*13 BIRTHPLACE OF MOTHER (city or town) *Balt. Md.*
(State or country)

14

Informant *Mrs. Mary Berlach*
(Address) *1605 N. Bradford St.*

15

Filed

*MAY 10 1920**ROBERT F. FRAUTER*
Registrar*Barthelme F. Clark*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 9* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 1, 1920, to May 9, 1920,
that I last saw him alive on *May 9, 1920*and that death occurred, on the date stated above, at *8:45 a. m.*

The CAUSE OF DEATH* was as follows:

Angina Pectoris(duration) yrs. *4* mos. *9* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Eugene L. Serrano*, M. D.*May 9 1920* (Address) *23148, Bulwer St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Baltimore Cemetery**May 12 1920*

20 UNDERTAKER

ADDRESS

*Henry Koch & Son**1341 E. Egan*

Exact statement of OCCUPA-

Instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42990

CERTIFICATE OF DEATH.

D42990

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hehren aged Home* ST.: *5* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Dina Rachel Korman

(a) RESIDENCE. NO.

115 Aisquith Street

ST.

WARD.

Norfolk Va.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

2 mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown 1885

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

65

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Benj Demarets

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant (Address)

Leuro 141 E. Calhoun

15

MAY 10 1920

ROBERT E. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 9 1920*

17

I HEREBY CERTIFY, That I attended deceased from *April 1, 1920*, to *May 9, 1920*, that I last saw her alive on *May 9, 1920*, and that death occurred, on the date stated above, at *2 p. m.*

The CAUSE OF DEATH* was as follows:

Myocarditis

CONTRIBUTORY (Secondary)

(duration) yrs. *6* mos. ds.(duration) yrs. *2* mos. ds.

18 Where was disease contracted

If not at place of death?

at home

Did an operation precede death?

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

clinical

(Signed)

W. J. Baughman, M. D.

57, 1920 Address)

210 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Hehren Friends Burial**5/10 1920*

20 UNDERTAKER

Jack Leuro

ADDRESS

141 E. Calhoun

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D42991

CERTIFICATE OF DEATH.

91

D42991

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

804 S. Fifth St.

ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thomas S. League Jr.

(a) RESIDENCE. NO.

804 S. Fifth St.

ST. 26 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

11

mos.

25

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 13-1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

11

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Thomas S. League Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

May M. McCombs

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Thomas S. League Sr. 804 S. Fifth St.

15

MAY 10 1920

REGISTRAR

BRIEF STATEMENT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 8 1920

17

I HEREBY CERTIFY, That I attended deceased from

5/29, 1920, to 5/8, 1920.

that I last saw him alive on 5/7, 1920.

and that death occurred, on the date stated above, at 10:53 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. McCombs M. D.

(Address) 2737 W. Eddys

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross Hayford Ave

May 10 1920

20 UNDERTAKER

ADDRESS

Lilly and Jailer

403 S. Wolfe

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42992

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2508 E. Federal ST.: 8 WARD)

2-FULL NAME

Bessie N. Moore(a) RESIDENCE. No. 2508 E. Federal ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7 - 19197 AGE Years Months Days If LESS than 1 day, hrs. or min. 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City10 NAME OF FATHER Raymond Moore11 BIRTHPLACE OF FATHER (city or town) (State or country) Md12 MAIDEN NAME OF MOTHER B. Lottis Fahey13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md14 Informant Raymond Moore (Address) 2508 E. Federal

15 MAY 10 1920 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 192017 I HEREBY CERTIFY, That I attended deceased from May 3rd, 1920, to May 7th, 1920.that I last saw him alive on May 7th, 1920.and that death occurred, on the date stated above, at 5³⁰ P. M.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. B. Lutz M. D., 19 (Address) 836 W. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Balto. Cem.May 10 1920

20 UNDERTAKER

Philip HerwigADDRESS 2016 Orleans

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42993

CERTIFICATE OF DEATH.

79 D42993
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 N. Broadway ST.: 7 WARD)

2-FULL NAME *Amelia Ann Be Joy*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 724 N. Broadway ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 50 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

*Female White Widowed*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Captain Alfred Be Joy*6 DATE OF BIRTH (month, day, and year) *Dec. 11 1832*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
87 4 29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Syford Delaware*
(State or country)10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town)
(State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)14 Informant *Elizabeth Johnson*
(Address) *724 N. Broadway*

15 MAY 10 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 9 1920*17 I HEREBY CERTIFY, That I attended deceased from *April 7 1920*, to *May 9 1920*.that I last saw him alive on *May 8 1920*.and that death occurred, on the date stated above, at *10:05 a.m.*

The CAUSE OF DEATH* was as follows:

Endocarditis(duration) yrs. mos. ds. *32*CONTRIBUTORY *Pulmonary Edema*
(Secondary)(duration) yrs. mos. ds. *2*18 Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *John G. Quinn*, M. D.May 9 1920 (Address) *Farmers Mt + Potomac St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Int. Carmel Cem.

20 UNDERTAKER

Philip Aernig

DATE OF BURIAL

May 12 1920

ADDRESS

2016 Orleans St.

Instructions on back of certificates. Exact statement of OCCUPATION should be classified. Property classified.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42994

CERTIFICATE OF DEATH.

170 D42994

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 N Broadway ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Grace A Stevens

(a) RESIDENCE. NO.

1516 N Broadway ST. 8 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

76 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

FemaleWhite

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John R Stevens

6 DATE OF BIRTH (month, day, and year)

Don't know

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

76

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

BaltoMD

10 NAME OF FATHER

John Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Grace Cornthwaite

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

BaltoMD

14

Informant (Address)

Mrs Lillian Hyman1516 N Broadway

15

MAY 10 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 5, 1920, to May 8, 1920.that I last saw her alive on May 8, 1920.and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis Urinary tests(Signed) W. M. M. M. D.Address 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Random ParkMay 11 1920

20 UNDERTAKER

ADDRESS

Herwig & Co2008 Allean

This certificate should be properly classified. Exact statement of OCCUPATION should be properly classified. See instructions on back of certificates.

Physicians should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D42995

CERTIFICATE OF DEATH

X 91

D42995

PLACE OF DEATH

CITY OF BALTIMORE (No. 214 E. Preston

ST. 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Ethel Florence Yates

(Residence in Baltimore: No. 214 E. Preston

St. yrs. mos. 3 weeks

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH April 4th, 1918 (Month) (Day) (Year)

7-AGE 2 yrs. 1 mos. 3 ds. if LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) N.Y.

10-NAME OF FATHER Wm. Gates

11-BIRTHPLACE OF FATHER (State or country) England

12-MAIDEN NAME OF MOTHER Ella Owen

13-BIRTHPLACE OF MOTHER (State or country) England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella F. Yates

(Address) 214 E. Preston St.

15 MAY 10 1920

ROBERT E. RAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 7th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 4, 1920, to May 7, 1920.

that I saw her alive on May 7, 1920.

and that death occurred, on the date stated above, at 7:10 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 4 ds.

Contributory (SECONDARY) Exhaustion

(Duration) yrs. mos. 1 ds.

(Signed) J. P. Robinson M. D.

May 8, 1920 (Address) 214 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or usual residence

New York

19-PLACE OF BURIAL OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

May 10, 1920

20-UNDERTAKER

William Cook

ADDRESS

582 E. North Ave.

20. UNDERTAKER ADDRESS
Chenoweth Son Chestnut Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42997

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 W Mosher ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1103 W Mosher St.; 61 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

white5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

Sept 18 1880
(Month) (Day) (Year)

7-AGE,

61 yrs., mos., ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House
work9-BIRTHPLACE,
(State or Country),Balt Md.

10-NAME OF FATHER,

Wm Brayden11-BIRTHPLACE OF FATHER
(State or Country),Balt Md.

12-MAIDEN NAME OF MOTHER

Mrs. Quinn13-BIRTHPLACE OF MOTHER
(State or Country),Balt Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M Brayden(Address) 1103 W Mosher St.

5-

MAY 10 1920

ROBERT J. KRAUTER

Filed

191

Baltimore City Health Department

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 8 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 6 1920, to May 8 1920,that I saw her alive on May 8 1920,and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:

Central apoplexy
(Duration) yrs. 3 mos. ds.CONTRIBUTORY
(Secondary)(Duration) yrs. mos. ds.(Signed) J. P. Keane M. D.May 8, 1920 (Address) 618 W. Calverton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Catholic Cemetery

DATE OF BURIAL,

5/11/1920

20-UNDERTAKER

John Howard & Son

ADDRESS

401 Hollister St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42998

CERTIFICATE OF DEATH.

151 D42998

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 N. Pulaski ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 426 N. Pulaski St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH.

..... May 9, 1920
(Month) (Day) (Year)

7-AGE.

..... yrs. mos. ds. LESS than 1 day.
..... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,
(State or Country).

Balt

10-NAME OF FATHER.

Herman Krawiec

11-BIRTHPLACE OF FATHER

(State or Country).

Balt

12-MAIDEN NAME OF MOTHER

Helen Krawiec

13-BIRTHPLACE OF MOTHER

(State or Country).

Balt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Helen Krawiec

(Address)

426 Pulaski St.

MAY 10 1920

ROBERT E. KRAUTER

Filed 191... B... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

..... May 9, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
..... May 9, 1920, to May 9, 1920,
that I saw her alive on May 9, 1920,
and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Premature Delivery
of 5th Month
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)..... (Duration) yrs. mos. ds.
(Signed) Howard W. Brown, M. D.
May 9, 1920 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

London Park

DATE OF BURIAL.

May 10, 1920.

20-UNDERTAKER

John Fields 1700 N. Lombard

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D42999

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *22 S. Carey*ST.; *19*

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Elizabeth E. Pratt*(Residence in Baltimore: No. *22 S. Carey St*St.; *Lifetime*

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE, *White*5-SINGLE, *Widowed*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH, *Unknown*

(Month)

(Day)

(Year)

7-AGE, *71*

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *None*(b) General nature of industry, business, or establishment in which employed (or employer) *ooo*9-BIRTHPLACE, (State or Country), *Balto. Md.*10-NAME OF FATHER, *Jeremiah M. Carthy*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ed Pratt*(Address) *22 S. Carey St*

5-

MAY 10 1920

ROBERT E. KRAUTER

Filed

191

BUTIN

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 9, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 8* 191*3* to *May 9* 192*0*,that I saw her alive on *May 18* 192*0*,and that death occurred, on the date stated above, at *7-15 A.M.*

The CAUSE OF DEATH* was as follows:

*Chronic Interstitial Nephritis**over 4 yrs. 4 mos. 5 ds.**None*

D43000

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43000

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3058 Stafford* ST.; *20* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Edwin Gerstenhauer*(Residence in Baltimore: No. *3058 Stafford* St.; *5* yrs., *5* mos., *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

*April**7**1915*

(Month)

(Day)

(Year)

7-AGE,

*5**1**1**ds.*

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Child

9-BIRTHPLACE, (State or Country),

Balto. Md.

10-NAME OF FATHER,

Hugo Gerstenhauer

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Margaret Anhalt

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Hugo Gerstenhauer*(Address) *3058 Stafford St.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*May**8**1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 8th 1920, to *May 8 1920*,that I saw him alive on *May 8 1920*,and that death occurred, on the date stated above, at *7:30 P. m.*

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Congestion(Duration) *8 hours*

CONTRIBUTORY (Secondary)

(Duration) *2 ds.*(Signed) *Thos. A. Schuler*

M. D.

May 8, 1920 (Address) *2505 W. Balto. St.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *5* yrs. *5* mos. *5* ds. In the State *5* yrs. *5* mos. *5* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Landon Park

DATE OF BURIAL,

May 11, 1920

20-UNDERTAKER

*C. W. Dill*ADDRESS *3109**Fredk. Ave.*

MAY 10 1920

ROBERT E. KRAUTER

B. M. R. Registrar

PHYSICIANS should state
of properly classified. Exact statement of OCCUPATION is very
back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43001

CERTIFICATE OF DEATH.

186

D43001

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital. ST.: 25 WARD) REGISTERED No. C.
2-FULL NAME Joseph Weinelt.
(Residence in Baltimore: No. English Consul Balto. Co. Md. St.: yrs. --- mos. --- ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <u>Male.</u>	4-COLOR OR RACE, <u>White.</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <u>Married.</u>
6-DATE OF BIRTH, <u>March 19th. 1872.</u> / (Month) (Day) (Year)		
7-AGE, <u>48</u> yrs. <u>1</u> mos. <u>18.</u> da.		IF LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <u>Laborer.</u> (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE, (State or Country), <u>Austria.</u>		
PARENTS.	10-NAME OF FATHER, <u>John Weinelt.</u>	
	11-BIRTHPLACE OF FATHER (State or Country), <u>Austria.</u>	
	12-MAIDEN NAME OF MOTHER <u>Do not know.</u>	
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Austria.</u>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Matilda Weinelt. (wife)
(Address) English Consul.

15-
Filed MAY 10 1920 191. ROBERT J. KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,
May 7th. 1920. 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry.
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry find that said deceased came to his death
(Inquest, au-
topsy or inquiry.)
on the day stated above.
The CAUSE OF DEATH* was as follows:
Accidental Fracture of Skull.
Struck by fall of a chain.
(Duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY
(Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) Otto M. Bernhard M. D.
(Coroner)
May 9th. 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place In the
of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Chesapeake Iron Works, Westport.
Former or usual residence English Consul.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,
Bedder Hill Cem. May 10. 1920
20-UNDERTAKER, ADDRESS
C. W. Dill 3109 Fredk. Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43002

D43002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* ST. *3* WARD)2-FULL NAME *John J. Smith*(a) RESIDENCE. NO. *213* ST. *Spring* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town). (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town). (State or country)

14

Informant (Address)

15

MAY 10 1920

ROBERT H. KRAUTER
Registrar

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 8* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

April 13, 19*20*, to *May 8*, 19*20*.that I last saw him alive on *May 8*, 19*20*.and that death occurred, on the date stated above, at *1:40* p. m.

The CAUSE OF DEATH* was as follows:

Cellulitis of neck(duration) — yrs. — mos. *25* ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. *5* ds.

18 Where was disease contracted?

If not at place of death?

Did an operation precede death? *yes* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Operation*(Signed) *J. O. Ridgely*, M. D.*5-8*, 19*20* (Address) *Mary Hos.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Wash. D. C.**May 10 1920*

20 UNDERTAKER

ADDRESS

W. G. Tucker & Son, N.Y. Pa.

Instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43003

CERTIFICATE OF DEATH.

170 D43003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 N Gilman ST.: 16 WARD)

2-FULL NAME

Martha E. Ensor

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

1124 N Gilman ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Widow

6 DATE OF BIRTH (month, day, and year)

March 29-1880

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7019

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

George Ensor

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Baumbitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Edna C. Tipton
Hampstead Md

MAY 10 1920

ROBERT E. KRAUTER
Registrar
Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 5, 1920, to May 8, 1920.that I last saw her alive on May 8, 1920.and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Uremia(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary)

Chronic Nephritis(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Do not knowDid an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? Urinary analysis(Signed) M. Baum and Good, M. D.6/9, 1920 (Address) 626 N. Gilman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Beckleyville, Baltimore, MdMay 11 1920

20 UNDERTAKER

ADDRESS

W. J. Tucker & SonsNorth and Pennsylvania

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43001

CERTIFICATE OF DEATH.

79 D43001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 255 Patapsco St Westport WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME HENRY CONRAD BENDER(a) RESIDENCE. No. 255 Patapsco Westport WARD.
(Usual place of abode)(If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
Elice Zamazo Bender (2nd wife)6 DATE OF BIRTH (month, day, and year) Oct. 13. 18357 AGE Years Months Days If LESS than 1 day, hrs. or min.
(84) Eighty four 6 26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Warburg, Prussia
(State or country) Germany10 NAME OF FATHER Henry Bender11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany14 Informant Wife Mrs. Henry Bender
(Address) 255 Patapsco St Westport15 Filed MAY 10 1920 JOSEPH E. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9th May 192017 I HEREBY CERTIFY, That I attended deceased from 8th May, 1920, to 9th May, 1920, that I last saw him alive on 8th May, 1920, and that death occurred, on the date stated above, at 4:00 A. M.

The CAUSE OF DEATH* was as follows:

Myocardial DegenerationCONTRIBUTORY (duration) yrs. mos. ds.
Atherosclerosis
(Secondary) (duration) yrs. mos. ds.18 Where was disease contracted
If not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Examination of heart(Signed) Calvin D. Woodruff M. D., 19 (Address) 234 Maryland Ave Westport

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Loudon Park May 11 1920

20 UNDERTAKER ADDRESS

M. S. Suckewson NY Pa

Instructions on back of certificates. Exact statement of state and county.

PHYSICIANS should
properly classified. Exact statement of OCCUPATION is very
important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43005

CERTIFICATE OF DEATH.

79 D43005

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1803 Lafayette St. WARD)

2-FULL NAME

(Residence in Baltimore: No. 1803 Lafayette St. yrs. mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widow*
(Write the word.)

6-DATE OF BIRTH, *May 7, 1867*
(Month) (Day) (Year)

7-AGE, *61* yrs. - mos. - ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Balto. Md.*

10-NAME OF FATHER, *John. Johnson*

11-BIRTHPLACE OF FATHER (State or Country), *Balto. Md.*

12-MAIDEN NAME OF MOTHER, *Gertrude Jensen*

13-BIRTHPLACE OF MOTHER (State or Country), *Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edward Edwards*

(Address) *1803 Lafayette St.*

15-

MAY 10 1920

ROBERT R. KRAUTER

DEPUTY CITY CLERK

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 8, 1920*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *J. H. Smith* M. D.

(Coroner.)

58 1810 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cedar Hill Cemetery*

DATE OF BURIAL, *May 10, 1920*

20-UNDERTAKER, *May E. Evans*

ADDRESS, *1428 S. Park St.*

D43006

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43006

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1123 N. Montford Ave* ST.; *8* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Lewis Steiner(Residence in Baltimore: No. *1123 N. Montford* St.; *63* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

July 24, 1856
(Month) (Day) (Year)

7-AGE,

63 yrs. 9 mos. 14 ds.

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Laborer*9-BIRTHPLACE,
(State or Country),*Balto Md.*

10-NAME OF FATHER,

*Charles Steiner*11-BIRTHPLACE OF FATHER
(State or Country),*Wash DC*

12-MAIDEN NAME OF MOTHER

*unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Matilda Steiner*(Address) *1123 N. Montford Ave*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 7, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 6, 1920*, to *May 7, 1920*, that I saw him alive on *May 7, 1920*, and that death occurred, on the date stated above, at *10:30* m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)*Cirrhosis of Liver*

(Duration)..... yrs..... mos..... ds.

(Signed) *B. P. Herzog* M. D.*May 8, 1920* (Address) *1305 N. Mt. Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn Home

DATE OF BURIAL,

MAY 10, 1920

20-UNDERTAKER

Geo. M. Fink & Son

ADDRESS

5117 W. Ave

Funeral Directors & Embalmers.

D43007

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D43007

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1230 Greenmount Ave* ST.: *10* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Catherine R. Evans*(a) RESIDENCE. No. *1230 Greenmount Ave* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mr. A. J. Evans*6 DATE OF BIRTH (month, day, and year) *Jan 2-1839*7 AGE Years *81* Months *4* Days *6* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House Work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)10 NAME OF FATHER *John W. Wilson*11 BIRTHPLACE OF FATHER (city or town) *Md* (State or country)12 MAIDEN NAME OF MOTHER *Caroline A. Hunter*13 BIRTHPLACE OF MOTHER (city or town) *Md* (State or country)14 Informant *A. B. Muller* (Address) *1230 Greenmount Ave*15 Filed *19* *ROBERT B. KRAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 8th 1920*

17 I HEREBY CERTIFY, That I attended deceased from

May 6th 1920, to *May 8th 1920*,that I last saw her alive on *May 8*, 1920,and that death occurred, on the date stated above, at *4 P* m.

The CAUSE OF DEATH* was as follows:

apoplexy(duration) yrs. mos. *2* ds.CONTRIBUTORY (Secondary) *Arteriosclerosis*(duration) *10* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *clinical*(Signed) *Wm. Pearce*, M. D.*5-10* 1920 (Address) *1-E Preston St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Greenmount**May 11, 1920*

20 UNDERTAKER

ADDRESS

*H. C. Wiedefeld 914 Greenmount*PHYSICIANS should state property classified. Exact statement of OCCUPA-
Instructions on back of certificates.

MAY 10 1920

Baltimore Health Dept.

Physicians should state
Exact statement of OCCUPA-
tions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Loma Aisey
HEALTH DEPARTMENT—CITY OF BALTIMORE

D43008

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

(If nonresident give city of town and State)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant (Address)

15

MAY 10 1920

ROBERT A. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/9 1920

17

I HEREBY CERTIFY, That I attended deceased from

5/7 1920, to 5/9 1920,

that I last saw her alive on 5/9 1920,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Fibroid

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Yes Date of 5/8/20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Edenbury VA

5-10 1920

20 UNDERTAKER

ADDRESS 517 N

H. B. Rammingson

Schneider St

Barnes
HEALTH DEPARTMENT—CITY OF BALTIMORE

D43009

CERTIFICATE OF DEATH.

D43009

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1751 N. Gay* ST.; *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Chas. D. Barnes*(Residence in Baltimore: No. *1751 N. Gay* St.; *1* yrs., *2* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Jan 11 1862
(Month) (Day) (Year)

7-AGE,

58 yrs. *3* mos. *28* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Barber

9-BIRTHPLACE,

(State or Country).

Richmond Va.

10-NAME OF FATHER,

Drury J. Barnes

11-BIRTHPLACE OF FATHER

(State or Country), *Virginia*

12-MAIDEN NAME OF MOTHER

Julia J. Moody

13-BIRTHPLACE OF MOTHER

(State or Country), *Georgia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Henry Barnes*(Address) *1843 Harford ave*

15- MAY 10 1920

ROBERT B. KRAUTER

Filed..... 191

Barial Reg.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 7 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from:

March 29 1920, to *May 7 1920*,that I saw him alive on *May 7 1920*,and that death occurred, on the date stated above, at *10³⁰ p.m.*

The CAUSE OF DEATH* was as follows:

Melanotic Sarcoma of the Esoph.(Duration)..... yrs. *1* mos. *21* ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. *1* mos. *14* ds.(Signed)..... *John J. Kenby*..... M. D.*5/8 1920* (Address) *3522 Greenmount*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

*Balto. Cem.**May 10th 1920*

20-UNDERTAKER

ADDRESS *2066**Philip Herwig**Orleans St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43010

CERTIFICATE OF DEATH.

151 D43010

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 Hanover St. ST.: 22 WARD)2-FULL NAME Robert B. Krauter(Residence in Baltimore: No. 225 Hanover St. St.: 22 yrs. 7 mos. 7 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male 4-COLOR OR RACE, white 5-SINGLE, married, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, May 7, 1920 (Month) (Day) (Year)7-AGE, 8 yrs. 7 mos. 7 ds. If LESS than 1 day, 8 hrs. or — min.8-OCCUPATION: (a) Trade, profession, or particular kind of work, none (b) General nature of industry, business, or establishment in which employed (or employer), 0009-BIRTHPLACE, (State or Country), Balto. Md.10-NAME OF FATHER, Wm. R. Rindmore11-BIRTHPLACE OF FATHER (State or Country), MD12-MAIDEN NAME OF MOTHER, Ellen Gray13-BIRTHPLACE OF MOTHER (State or Country), MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. R. Rindmore(Address) 225 Hanover St.15- MAY 10 1920 ROBERT B. KRAUTERFiled 191 Baltimore City Health Department

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 7, 1920 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 7, 1920, to May 7, 1920, that I saw him alive on May 7, 1920, and that death occurred, on the date stated above, at 28 m.

The CAUSE OF DEATH* was as follows:

7 mos. child
cause in Rindmore
(Duration) 7 yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) 7 yrs. 7 mos. 7 ds.
(Signed) Wm. R. Rindmore M. D.
(Address) 132 N. E. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs. 7 mos. 7 ds. In the State 7 yrs. 7 mos. 7 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

JOHNS HOPKINS HOSPITAL May 8, 1920

20-UNDERTAKER ADDRESS

Wm. R. Rindmore

PHYSICIANS should state exact statement of OCCUPATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43011

CERTIFICATE OF DEATH.

28 D43011

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 W Fort ave. ST.: 23 WARD)

2-FULL NAME Marie J. Taylor

(a) RESIDENCE. No. 9 W. Fort ave. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 MAY 10 1920 ROBERT B. KAUTER Registrar

16 DATE OF DEATH (month, day, and year) May 9 1920

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1920, to May 9, 1920, that I last saw him alive on May 8, 1920, and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pharyngitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Glucose

(Signed) R. B. Campbell, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cedar Hill Cem May 12 1920

20 UNDERTAKER ADDRESS

M. G. Flynn 1422 Light

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43011

CERTIFICATE OF DEATH.

28 D43011

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 W Fort ave. ST.: 23 WARD)

2-FULL NAME

Marie J. Taylor

(a) RESIDENCE. No.

9 W. Fort ave.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 MAY 10 1920 ROBERT B. KAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1920

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1920, to May 9, 1920,

that I last saw him alive on May 8, 1920,

and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pharyngitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Glucose

(Signed) R. B. Campbell, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cedar Hill Cem May 12 1920

20 UNDERTAKER ADDRESS

M. G. Flynn 1422 Light

Every item of information should be properly classified. Exact statement of OCCUPATION. See instructions on back of certificates.

Spec. 6-2-19 H. P. Co. 1000 Bks.

D43012

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43012

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 Beran ST. 23 WARD)

2-FULL NAME Lewis E. Fannon

(a) RESIDENCE. No. 923 Beran ST. WARD. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 26 1920

7 AGE Years 2 Months 12. Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER James Fannon

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ross

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant James Fannon (Address) 923 Beran St.

15 MAY 10 1920 Robert H. Kautler Barial Permit

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

23

ST. WARD

ST. WARD

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 - 1920

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1920, to May 8, 1920, that I last saw him alive on May 7, 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) Unknown

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 923 Beran St

Did an operation precede death? No Date of

Was there an autopsy? none

What test confirmed diagnosis? none

(Signed) J. H. Ingram M. D.

. 19 (Address) 2424 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St Peters Cemetery 5/10/20

20 UNDERTAKER ADDRESS

James Dignam, Son 1000 S. Paca

PHYSICIANS should state
properly classified. Exact statement of OCCUPATION is very

of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43013

CERTIFICATE OF DEATH.

D43013

166 May 9, 1942
166 May 9, 1942

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *either on Back Street or on way*)

2-FULL NAME

(Residence in Baltimore: No. *933 S. S. Lenwood*)

ST.: *Ward*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH, *1* (Month) (Day) (Year)

7-AGE, *23* yrs. *3* mos. *6* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Freeman* (b) General nature of industry, business, or establishment in which employed (or employer) *Relay*

9-BIRTHPLACE, (State or Country), *Baltimore*

PARENTS. 10-NAME OF FATHER, *A. Parks* 11-BIRTHPLACE OF FATHER (State or Country), *Baltimore* 12-MAIDEN NAME OF MOTHER *Mamie Lewis* 13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) *Mr. R. H. Parks* (Address) *933 S. Lenwood*

15-MAY 10 1942 Filed *101* ROBERT E. BRAUTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 8, 1942* (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, au- *topsy or inquiry*) find that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows: *either asphyxia due to smothering in bed during or drowned from water on floor. in either case a foul odor.*

CONTRIBUTORY *Indur.* (Secondary) (Duration) yrs. mos. ds. (Signed) *W. H. White* (Coroner) M. D. *May 10, 1942* (Address) *1039 Woodward*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cemetery* DATE OF BURIAL, *May 11, 1942*

20-UNDERTAKER *Henry W. Meas & Son* ADDRESS *705 N. Calvert*

D43014

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43014

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

ST.

WARD) 16

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed MAY 10 1920

101.

ROBERT A. KRAUTH
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said
(Inquest, au-

topsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. skull - caused by
accidental fall from window
at City Health Dept.

CONTRIBUTORY

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

(Coroner.)

M. D.

May 10, 1920

(Address)

1629 Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

then born in the

of death.... yrs.... mos.... ds. State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

PLACE OF BURIAL OF DECEASED

DATE OF BURIAL,

City Family Cemetery May 11, 1920

CO-REGISTRAR

ADDRESS

E. J. Medfield, Jr. M.D.

Instructions on back of certificates. Exact statement of OCCUPA-
tion should be stated.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43015

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43015

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2005 Longwood St.* ST. *15* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Milton Sowers McDaniel

(a) RESIDENCE. NO.

2005 Longwood St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

5a If married, widowed, or divorced

HUSBAND of

Ann C. Virginia McDaniel

6 DATE OF BIRTH (month, day, and year) *Mar 8, 1859*

7 AGE Years *61* Months *2* Days *2* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Salesman 066*

(b) General nature of industry, business, or establishment in which employed (or employer) *Not employed for 6 months past*

(c) Name of employer *Mt Joy Co.*

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER *William M. McDaniel*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Amesbury, Va.*

12 MAIDEN NAME OF MOTHER *Ann C.*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Amesbury, Va.*

14 Informant *Ann C. McDaniel (Son)*

15 Filed *MAY 10 1920* 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 9* 19 *20*

17 I HEREBY CERTIFY, That I attended deceased from *May 6*, 19 *20*, to *May 9*, 19 *20*, that I last saw him alive on *May 8*, 19 *20*.

and that death occurred, on the date stated above, at *4:00 A. M.*

The CAUSE OF DEATH* was as follows: *Evidently some brain lesion - Attack began with convulsion, followed by continuous coma except for convulsions at intervals; not uraemic - Duration - 3 1/2 ds.*

CONTRIBUTORY *Atheromatous vessels,* (Secondary) (duration) *several* yrs. mos. ds.

18 Where was disease contracted if not at place of death? *X*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Urinary* (Signed) *O. H. Hoffman* M. D.

, 19 (Address) *2100 W. North Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Frederick Md. May 11 1920

20 UNDERTAKER *E. A. Wiedefeld*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43016

D43016

CERTIFICATE OF DEATH.

X 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

328 S. Highland

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

James Davis

(a) RESIDENCE. No.

328 S. Highland

ST.

WARD.

Cambridge Md.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

8 mos.

ds.

How long in U. S., if of foreign birth?

82 yrs.

10 mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Widower

6a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

Mary Jane Davis

6. DATE OF BIRTH (month, day, and year)

July - 1836

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

82

10

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer)

Lumber Hammer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Talbot Co. Md.

10 NAME OF FATHER

John Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Antennum

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Walter J. Davis
328 S. Highland

15

MAY 10 1920

ROBERT H. EDWARDS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 10 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 21 1920, to May 8 1920

that I last saw him alive on May 8

and that death occurred, on the date stated above, at 9:25 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Infantile Pythriety.
Arteriosclerosis.

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos. ds.

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. E. M. Cavahan M. D.

May 10 1920 (Address) 3508 Bank St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cambridge Dorchester Co. Md

May 10 1920

20 UNDERTAKER

ADDRESS

Philip Hedberg

2016 Orleans

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43017

CERTIFICATE OF DEATH.

D43017

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2938 St. Paul Street ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Theodore Stone

(a) RESIDENCE. No. 2938 St. Paul Street ST., 12 WARD. (Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? 60 yrs. 5 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Clara Brinton Stone

6 DATE OF BIRTH (month, day, and year) Nov.-21-1859

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

60

5

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pres't. Md. Casualty Co.

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance.

(c) Name of employer Md. Casualty Company

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

10 NAME OF FATHER James Harvey Stone

11 BIRTHPLACE OF FATHER (city or town) Rutland (State or country) Massachusetts.

12 MAIDEN NAME OF MOTHER Harriet Fusselbaugh

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Dr. Harvey B. Stone, (Son) (Address) 2938 St. Paul St.

15 MAY 10 1920 ROBERT A. KAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 27, 1920, to May 9, 1920,

that I last saw him alive on May 9, 1920,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Walter A. Bangerter, M. D.

19 (Address) 900 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

GreenMount Cemetery

DATE OF BURIAL

May-12-1920

20 UNDERTAKER

STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

Missing
#D 43018

D43019

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43019

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Med. School Hospital* ST.; *9* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *1726 Montpelier St.* ST., *9* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Charles A. Wachsmuth*6 DATE OF BIRTH (month, day, and year) *Dec 19, 1891*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *28* *4* *28*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Joseph Stiff

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

V. a.

12 MAIDEN NAME OF MOTHER

Adrian Bull

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*V. a.*14 Informant (Address) *Charles A. Wachsmuth 1726 Montpelier St.*15 Filed *Robert P. Harrison,*

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 9 1920*

17 I HEREBY CERTIFY, That I attended deceased from

4/26, 19*20*, to *5/9*, 19*20*.that I last saw *her* alive on *5/9*, 19*20*.and that death occurred, on the date stated above, at *8:00 p.m.*

The CAUSE OF DEATH* was as follows:

Acute Nephritis(duration) yrs. mos. *14* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *4/28/20*Was there an autopsy? *no*What test confirmed diagnosis? *Urinary tests*(Signed) *Edw. Stiff*, M. D., 19 (Address) *Med. School Hospital.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Middlesex Co. Virginia *May 11 1920*

20 UNDERTAKER

ADDRESS

H. Sander Sons 1710 Flat St.

N. B.—WRITE INFORMATION SHOWN IN CAUSE OF DEATH SECTION IS A

may be properly on back of certificates.

D43020

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43020

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2437 E Monument ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2437 E Monument St.; 52 yrs., 5 mos., 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. married
(Write the word.)

6-DATE OF BIRTH, Nov 24 1868, 1.....
(Month) (Day) (Year)

7-AGE, 52 yrs., 5 mos., 14 ds. If LESS than 1 day,hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Zimmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

10-NAME OF FATHER, Carl Heid

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Barbra Heid

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) May Heid(Address) 2437 E Monument

Filed MAY 10 1920 Robert P. Harrison,
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 9, 1912..
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1912, to May 1912, that I saw him alive on May 1912, and that death occurred, on the date stated above, at 230 A m.
The CAUSE OF DEATH* was as follows:

Myocardial degeneration
hypertension
arteriosclerosis (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) acute coronary thrombosis
(Duration).....yrs.....mos.....ds.

(Signed) W. F. Harrison M. D.5-9-20, 1912 (Address) 801 N. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Holy Redeemer May 11, 1912..

20-UNDERTAKER ADDRESS

Mrs. G. Miller 2324 E. Pratt

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43021

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43021

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 N. Wolfe ST. 8 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles F. Klein(Residence in Baltimore: No. 1100 N Wolfe St.; 56 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male4-COLOR OR RACE White5-SAMPLE
MARRIED Married
WIDOWED
OR DIVORCED
(Write the word.)6-DATE OF BIRTH, Jan 2nd, 1861

(Month)

(Day)

(Year)

7-AGE, 60 yrs., 4 mos., 6 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work Produce(b) General nature of industry, business, or establishment in which employed (or employer) 0459-BIRTHPLACE, (State or Country), New York10-NAME OF FATHER, George P. Klein11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER Unknown13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert P. Harrison(Address) 227 N. Calhoun Ave

15-

Robert P. Harrison,Filed May 10 1920

191.....

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 8, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from May 10 1911, to May 8 1920,that I saw him alive on May 6 1920,and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease(Duration) 5 yrs., 0 mos., 0 ds.

CONTRIBUTORY (Secondary)

(Duration) 5 yrs., 0 mos., 0 ds.(Signed) Chas E. Gansline M. D.5-9, 1920 (Address) Towson Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London ParkDATE OF BURIAL, May 11, 1920

20-UNDERTAKER

ADDRESS

Mrs. B. Miller South StreetWRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43022

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43022

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Uriah P. Cox*

(a) RESIDENCE. No. *Glyndon Mar.* ST. *Glyndon Md* WARD. *Glyndon Md*
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *12* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of *Annie Cox* (or) WIFE of *Oct 14 1860*

6 DATE OF BIRTH (month, day, and year)

7 AGE Years *60* Months *6* Days *15* If LESS than I day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Farmer*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) *Md* (State or country)

10 NAME OF FATHER *John Cox*

11 BIRTHPLACE OF FATHER (city or town) *Md.* (State or country)

12 MAIDEN NAME OF MOTHER *T Price*

13 BIRTHPLACE OF MOTHER (city or town) *Md.* (State or country)

14 Informant *Mrs Annie Cox* (Address) *Glyndon Md*

15 Filed *Robert P. Harrison,* Registrar

MAY 10 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 8 1920*

17 I HEREBY CERTIFY, That I attended deceased from *Apr 25*, 19*20*, to *May 8*, 19*20*, that I last saw him alive on *May 8*, 19*20*, and that death occurred, on the date stated above, at *3 p* m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

CONTRIBUTORY (Secondary) *Infected Wound* (duration) yrs. mos. ds.

18 Where was disease contracted *Glyndon Mar.* if not at place of death?

Did an operation precede death? *yes* Date of *5/8/20*

Was there an autopsy?

What test confirmed diagnosis? (Signed) *C. R. Schneider*, M. D., 19 (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Prince Ridge Cemetery

May 11 1920

20 UNDERTAKER

J. F. Eline

ADDRESS

Reston Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43023

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43023

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225-E. Ave. ST. 17 WARD)

2-FULL NAME Ellen Baldwin

(a) RESIDENCE. NO. 1225-E North Ave ST. 17 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of George E. S. Baldwin (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 12/83

7 AGE Years 88 Months 7 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond (State or country) Fa.

10 NAME OF FATHER John Morris

11 BIRTHPLACE OF FATHER (city or town) Fa. (State or country)

12 MAIDEN NAME OF MOTHER Anne Seabridge

13 BIRTHPLACE OF MOTHER (city or town) Fa. (State or country)

14 Informant Mr. James A. Baldwin (Address) Robert P. Harrison, Fa.

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1920, to May 8, 1920.

that I last saw her alive on ", 1920.

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

CONTRIBUTORY (Secondary) Central paralysis (duration) 4 yrs. mos. ds.

(duration) 24 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? George A. Hartman (Signed) M. D.

1920 (Address) 2214 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cedar Hill Nov 11 1920

20 UNDERTAKER ADDRESS

Wm. Carter 84 E. Hill

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43021

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43021

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2208 Ashland ST.: 7 WARD)

2-FULL NAME

(a) RESIDENCE. No. 2208 Ashland ST.: 7 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? 39 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elyzabeth Turk

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meat Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bohemia (State or country)

10 NAME OF FATHER James Turk

11 BIRTHPLACE OF FATHER (city or town) Bohemia (State or country)

12 MAIDEN NAME OF MOTHER Joseph Stephan

13 BIRTHPLACE OF MOTHER (city or town) Bohemia (State or country)

PARENTS

14 Informant (Address) Frank M. Turk 2208 Ashland

15 Filed MAY 10 1920

Robert I. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1920

17

I HEREBY CERTIFY, That I attended deceased from Jan 17 1920 to May 8 1920

that I last saw him alive on May 6 1920

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Enteritis (Intestinal)

(duration) 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) M. S. Gibney M. D.

(Address) 600 W. Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer May 11 1920

20 UNDERTAKER Frank Turk ADDRESS 1406 Ashland

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of SUPPLEMENTARY INFORMATION is very important. See instructions on back of certificates.

Spec.—6-9-1914 H. P. Co.—1000 Bks.

D43025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43025

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *15* WARD)

2-FULL NAME

(a) RESIDENCE. No. *1367 N. Carey St.* ST. *15* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug - 1852*

7 AGE Years *57* Months *8* Days *8* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Antennist 886*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Maryland* (State or country)

10 NAME OF FATHER *James Queen*

11 BIRTHPLACE OF FATHER (city or town) *Antennist* (State or country)

12 MAIDEN NAME OF MOTHER *Martha Queen*

13 BIRTHPLACE OF MOTHER (city or town) *Maryland* (State or country)

14 Informant *Hospital Record* (Address) *St. 21*

15 *May 10 1920* Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 8* 19*20*

17 I HEREBY CERTIFY, That I attended deceased from

March 20, 1920, to May 8, 1920,

that I last saw him live on *May 8, 1920,*

and that death occurred, on the date stated above, at *6:30 a. m.*

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

CONTRIBUTORY (Secondary)

(duration) yrs. *4* mos. ds.

Bronchopneumonia

(duration) yrs. mos. ds. *5*

18 Where was disease contracted if not at place of death? *At home*

Did an operation precede death? *Yes* Date of *April 15, 1920*

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Autopsy*

(Signed) *Levitt Holman*, M. D.

, 19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *St. Peter's A. C. C. Co* DATE OF BURIAL *May 15, 1920*

20 UNDERTAKER *George A. Hollan* ADDRESS *1651 Union Hill Ave*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43026

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43026

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital*

ST.: *2* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *1733 Fleet*

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *24* yrs. mos. ds.

How long in U. S., if of foreign birth? *24* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *March 30-1896*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *24 1 9*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Plumber 059

(b) General nature of industry, business, or establishment in which employed (or employer)

" "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Frances Haduck

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Frances Haduck 1733 Canton Ave

MAY 10 1920

Filed

19

Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 9 1920*

17

I HEREBY CERTIFY, That I attended deceased from *April 29*, 19*20*, to *May 9*, 19*20*, that I last saw him alive on *May 9*, 19*20*, and that death occurred, on the date stated above, at *9 A. m.*

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

Encephalitis Lethargica

(duration) yrs. mos. *21* ds.

18 Where was disease contracted if not at place of death? *unknown*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Clinical examination*

(Signed) *Daniel Miller* M. D.

. 19 (Address) *St Joseph's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary

5/11 1920

20 UNDERTAKER

William Gialkowski 618 Eastern

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43027

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43027

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *640 W. Lombard* ST.: *4*)

2-FULL NAME *Mr. D. S. S. S.*

(Residence in Baltimore: No. *640 W. Lombard*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Went, *1*
(Month) (Day) (Year)

7-AGE,

49

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Rather

058

9-BIRTHPLACE,
(State or Country),

N. York State
Don't know

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May *9*, *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

find that said deceased came to his death
(Inquest, autopsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

*From history, I say Pulmonary
Tuberculosis*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. K. G. G.* M. I.

5-10, *1920* (Address) *117 W. Lombard*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Jamesdown *May 11*
1200 W. Lombard

D43028

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43028

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST.; *5* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *135 N Exeter St* St.; *30* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Widowed

6-DATE OF BIRTH,

Unknown, *1828*
(Month) (Day) (Year)

7-AGE,

92 yrs. mos. ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, business, or establishment in which
employed (or employer).*Merchant*
*045*9-BIRTHPLACE,
(State or Country).*Russia*10-NAME OF
FATHER,*Unknown*11-BIRTHPLACE
OF FATHER
(State or Country).*Russia*12-MAIDEN NAME
OF MOTHER*Unknown*13-BIRTHPLACE
OF MOTHER
(State or Country).*Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

Robert P. Harrison,

Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May, *10*, *1920*.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 19, 191*9*, to *May 10*, 191*9*,that I saw him alive on *May 10*, 191*9*,and that death occurred, on the date stated above, at *8:45* m.

The CAUSE OF DEATH* was as follows:

Heart failure
.....
.....

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

May 10, 191*9*. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? *at home*Former or usual residence *135 N Exeter St*

19-PLACE OF BURIAL OR REMOVAL,

Hebrew Hospital

DATE OF BURIAL,

May 10, 1920

20-UNDERTAKER

Jack Lewis

ADDRESS

1411 E Balto

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

MAY 10 1920

D43029

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43029

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. Hospital* ST.; *7* WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Walter Smith*(Residence in Baltimore: No. *1014 N. Gay* St.; *6* yrs. *6* mos. *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH

About *1882*
(Month) (Day) (Year)

7-AGE,

38

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Fireman**037*

9-BIRTHPLACE, (State or Country),

Pennsylvania

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Hospital Records*

(Address).....

15-

Robert P. Harrison,

Filed *May 10 1920*

191.....

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 8 *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr. 17 *1920*, to *May 8* *1920*,that I saw him alive on *May 8* *1920*,and that death occurred, on the date stated above, at *12:15 a.m.*

The CAUSE OF DEATH* was as follows:

Myocarditis (Chronic)
(auricular fibrillation)(Duration) *2* yrs. *2* mos. *6* ds.CONTRIBUTORY *Chronic Cordiac Dilatation*
(Secondary)(Duration) *2* yrs. *2* mos. *6* ds.(Signed) *Lyman S. Abbott* M. D.*May 8* *191* (Address) *Franklin Sq. 1400*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *6* yrs. *6* mos. *6* ds. In the State *6* yrs. *6* mos. *6* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Philadelphia Pa.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

*Holy Redeemer**May 11, 1920*

20-UNDERTAKER

ADDRESS

*Harry H. Witzke**1531 W. Lombard*WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

D43030

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

D43030

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 George ST.: 17 WARD)2-FULL NAME Wm. Roberts(Residence in Baltimore: No. 730 George St.; 2 yrs., 2 mos., 2 da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX Male4-COLOR OR RACE, Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married6-DATE OF BIRTH, 1857

(Month)

(Day)

(Year)

7-AGE, 69

yrs.

mos.

da.

If LESS than 1 day.

...hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. John 886(b) General nature of industry, business, or establishment in which employed (or employer). Tullman9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, August Roberts11-BIRTHPLACE OF FATHER (State or Country), Acknowled12-MAIDEN NAME OF MOTHER, Ann Sproul13-BIRTHPLACE OF MOTHER (State or Country), Ad

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Former Roberts(Address) 730 George St.

15-

MAY 11 1920

ROBERT H. TRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 8th, 1920.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1919, to May 8th 1920 that I saw him alive on May 8th 1920 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Pul. T.B.(Duration) 2 yrs., 2 mos., 2 ds.CONTRIBUTORY (Secondary) Exhaustion(Duration) 2 yrs., 2 mos., 2 ds.(Signed) A. H. Ellis M. D.19120 (Address) 924 N. 2nd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs., 2 mos., 2 ds. In the State 2 yrs., 2 mos., 2 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel ParkDATE OF BURIAL, May 11, 192020-UNDERTAKER, Daniel EastonADDRESS 915WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *231 N. Arlington* ST.; *18* WARD)

2-FULL NAME

(Residence in Baltimore: No. *231 N. Arlington* St.; *18* yrs., *0* mos., *0* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *al*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *1878*

(Month)

(Day)

(Year)

7-AGE, *47*

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Laundress*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Baltimore Md*10-NAME OF FATHER, *out known*11-BIRTHPLACE OF FATHER (State or Country), *out known*12-MAIDEN NAME OF MOTHER, *out known*13-BIRTHPLACE OF MOTHER (State or Country), *out known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Daniel Easton*(Address) *916 Pennsylvania*

15- MAY 11 1920

ROBERT R. KRAUTER

Filed..... 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 9*, 191*1*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 17* 191*1*, to *May 9* 191*1*that I saw him alive on *May 9* 191*1*and that death occurred, on the date stated above, at *5:00* m.

The CAUSE OF DEATH* was as follows:

Mammalian Gaster
Canceroma

(Duration)..... yrs. mos. ds.

CONTRIBUTORY..... (Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *H. H. Hadlock* M. D.319 So. (Address) *112 N. Calver*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Luke's*DATE OF BURIAL, *May 12, 1920*20-UNDERTAKER, *Daniel Easton*ADDRESS *916 Pennsylvania*WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

757

D43032

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

D43032

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 760 W. Mulberry St. 17 WARD)

2-FULL NAME Frank Massa

(Residence in Baltimore: No. 760 W. Mulberry St. 10 yrs. 10 mos. 10 ds.)

REGISTERED No. C.

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Sept 3, 1885

7-AGE, 34 yrs. 8 mos. 7 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Day laborer

(b) General nature of industry, business, or establishment in which employed (or employer), 040

9-BIRTHPLACE, (State or Country), Tampa, Florida

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER, Lattie Massa

13-BIRTHPLACE OF MOTHER (State or Country), Florida

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Beatrice Massa

(Address) 760 W. Mulberry St.

MAY 11 1920

Filed 101

ROBERT R. KRAUTER

Racial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 10, 1920

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) yrs. 3 mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(Duration) yrs. 3 mos. 1 ds.

(Signed) J. A. M. Hennessy, M. D. (Coroner.)

May 10, 1920 (Address) 3002 E. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem.

DATE OF BURIAL, May 12

20-UNDERTAKER, Daniel Earls

ADDRESS, 8916

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43033

CERTIFICATE OF DEATH.

79 D43033

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 Elna Pl. ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edna Duffy

(a) RESIDENCE. NO.

928 Elna Pl.

ST.: 17 WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 1 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Col. 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE 18 Years Months Days If LESS than 1 day, 0 hrs. 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Apprentice
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer Va.

9 BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant M. Duffy (Address) 928 Elna Pl.

15 MAY 11 1920 ROBERT E. KEASTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1920

17 I HEREBY CERTIFY, That I attended deceased from May 3, 19 20, to May 10, 19 20, that I last saw him alive on May 9, 19 20, and that death occurred, on the date stated above, at 3:45 p. m. The CAUSE OF DEATH* was as follows: acute pneumonia, pleurisy

CONTRIBUTORY (Secondary) Valvular Disease (duration) 12 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physician (Signed) J. G. Shiple M. D.

519 1920 (Address) 206 N. Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Blofton Va DATE OF BURIAL May 11 1920

20 UNDERTAKER Daniel E. Egan ADDRESS 96 Deane

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43034

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43034

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1572 Laurens ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 372 Laurens ST. WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? 24 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Milton Royal

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE Years 40 Months — Days — If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) Wilmington (State or country) N. C.

10 NAME OF FATHER Prince Swain

11 BIRTHPLACE OF FATHER (city or town) N. C. (State or country)

12 MAIDEN NAME OF MOTHER Caroline

13 BIRTHPLACE OF MOTHER (city or town) N. C. (State or country)

14 Informant Emma Royal (Address) 372 Laurens St

15 Filed MAY 11 1920 ROBERT F. LEATHER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4th 19 20

17 I HEREBY CERTIFY, That I attended deceased from Jan 15th, 19 20, to May 7th, 19 20, that I last saw her alive on May 7th, 19 20, and that death occurred, on the date stated above, at 12 midnight. The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY Carcinoma - Stomach? (Secondary)

(duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Gordon Wilson, M. D.

, 19 (Address) 4. E. Preston St. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Auburn May 11 1920

20 UNDERTAKER ADDRESS 142

John H. Traders W. Hill St

Serial Permit Stamp

D43035

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 D43035

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 *Grindells' Ct.* ST.; 22 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 722 *Grindells' Ct.* St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

male

4-COLOR OR RACE,

*Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

June, 1871
(Month) (Day) (Year)

7-AGE,

49 yrs., mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *David Reibner*(Address) *109 St. Louis St.*

15-

Filed

MAY 11 1920

ROBERT E. TRAUTER

Baltimore Health Department

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May, 10, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 10* 1920, to *May 10* 1920, that I saw him alive on *May 10* 1920, and that death occurred, on the date stated above, at *40* m.

The CAUSE OF DEATH* was as follows:

Robert Reibner
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. P. Reibner* M. D.*May 10*, 1920. (Address) *109 St. Louis St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Int. Auburn**May 10 1920*

20-UNDERTAKER

ADDRESS

*John H. Trautner**142*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Physicians should state EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43036

CERTIFICATE OF DEATH.

91 D43036

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 N. Bental ST.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Lewis

(a) RESIDENCE. No. 609 N. Bental ST., 7 WARD.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Dec 20 - 1908

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 1 yr. 1 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) MD

10 NAME OF FATHER James Lewis

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) MD

12 MAIDEN NAME OF MOTHER Ann Susco

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) MD

14 Informant James Lewis (Address) 609 N. Bental

15 Filed MAY 11 1920 ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 19 20

17 I HEREBY CERTIFY, That I attended deceased from Apr 20, 19 20, to May 9, 19 20, that I last saw him alive on May 19, 19 20, and that death occurred, on the date stated above, at 5-2 p. m.

The CAUSE OF DEATH* was as follows: Broncho Pneumonia

(duration) yrs. mos. ds. 7

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. C. Brown, M. D. (Address) 224 S. Bental

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Asbury May 11 1920

20 UNDERTAKER ADDRESS 1502

John W. Henderson E. Monument

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43037

CERTIFICATE OF DEATH.

REGISTERED NO.

D43037

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAY 11 1920

ROBERT H. KRAUTER

Registrar

Serial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from April 24, 1920, to May 10, 1920, that I last saw him alive on May 10, 1920, and that death occurred on the date stated above, at 8:45 P. M.

The CAUSE OF DEATH* was as follows:

Abd.-Stomach-Carcinoma-Pyloric Obstruction-Tumor adherent to liver and hepatic colon.

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of May 1, 1920

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) L. Clarence Cohen, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

John Deitchel, 1717 N. T. Ave.

PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43040

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-078 D43040

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 Cambridge ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rozalia Jaskulski

(a) RESIDENCE. No. 2104 Cambridge ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female white married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Frank Jaskulski

6 DATE OF BIRTH (month, day, and year) Oct 1, 1894

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

25 7 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife. 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt., Md.

10 NAME OF FATHER John Bayet

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Micheline Pawlaka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Mrs. Micheline Bayet (Mother) (Address) 617 S. Bond St.

15 MAY 11 1920 ROBERT E. TRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1920

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1920, to May 10, 1920, that I last saw him alive on May 10, 1920, and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY Acute myocarditis (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) Chas. V. Keeney, M. D.

, 19 (Address) 221 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Rosary Cem, May 13 1920

20 UNDERTAKER

M. F. Sadowski, 705 S. Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43041

CERTIFICATE OF DEATH.

172 D43041

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 E. Barney ST.: 23 WARD)

2-FULL NAME

George A. Bradburn

(a) RESIDENCE. NO.

26 E. Barney ST., 24 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

4 yrs.

3 mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb. 4, 1916

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md

10 NAME OF FATHER

Harold D. Bradburn

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Edna D. Bradburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

George A. Bradburn 26 E. Barney

15

MAY 11 1920

ROBERT H. KAUFER Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5/9/20

17

I HEREBY CERTIFY, That I attended deceased from

4/19/20

19

to

5/9/20

19

that I last saw him alive on

5/8/20

19

and that death occurred, on the date stated above, at

m.

The CAUSE OF DEATH* was as follows:

Cerebral Pachymeningitis

(duration)

yrs.

mos.

21

ds.

CONTRIBUTORY (Secondary)

Craniatum

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

P. K. Tawler

M. D.

(Address)

1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Balto Cent. Bur.

4/11 1920

20 UNDERTAKER

ADDRESS

Mrs. J. E. Evans 728 N. Charles St.

Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43043

55-091
D43043

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Charles St Ave. Ext. 27 ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Whitridge Garrett

(a) RESIDENCE. NO. Charles St Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of J. Harrison Garrett. (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851. 7-15

7 AGE Years 68 Months 9 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Lady at Home. (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md (State or country)

10 NAME OF FATHER Horatio Whitridge

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Hall

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant John W. Garrett. (Address) Charles St Ave. Ext. 27

15 MAY 11 1920 JOSEPH B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9th 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb 9th 1920, to May 9th 1920, that I last saw him alive on May 9th 1920, and that death occurred, on the date stated above, at 10:40 P. M. The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis (duration) 28 yrs. 28 mos. 28 ds.

CONTRIBUTORY Tubercular Bronchopneumonia (Secondary) (duration) 28 yrs. 28 mos. 28 ds.

18 Where was disease contracted at Place of Birth if not at place of death?

Did an operation precede death? No. Date of no.

Was there an autopsy? No.

What test confirmed diagnosis? Lumbar puncture

(Signed) Frank Martini M. D. (Address) 1000 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL 5-11 1920

20 UNDERTAKER Henry W. Jackson and Sons Co ADDRESS McPulloh Orchard

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43044

HEALTH DEPARTMENT-CITY OF BALTIMORE
MARGARET J. HARVEY
64
CERTIFICATE OF DEATH

D4304

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. Beidle Telfer Sanatorium ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellis James Harvey

(Residence in Baltimore: No. 1219 W. Lofayeth Ave St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Widow (Write the word)

6-DATE OF BIRTH Sept 7, 1851 (Month) (Day) (Year)

7-AGE 68 yrs. 8 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore

10-NAME OF FATHER John Slegghorn

11-BIRTHPLACE OF FATHER (State or country) Ireland

12-MAIDEN NAME OF MOTHER Ellary Anderson

13-BIRTHPLACE OF MOTHER (State or country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret J. Harvey

(Address) Owens Mills, Md.

15 MAY 11 1920

Filed

191

ROBERT B. KRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 11, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1919, to May 1920, that I saw him alive on May 10, 1920, and that death occurred, on the date stated above, at 2:45 A.M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
Chronic Nephritis
Cerebral Hemorrhage (Sept. 1919)

(Duration) 3 yrs. mos. ds.

Contributory Myocarditis - General (SECONDARY) arterio

(Duration) 2 yrs. mos. ds.

(Signed) John S. Bishop M. D.
May 11, 1920 (Address) 828 N. Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. 11 mos. ds. In the Beidle-Telfer State yrs. mos. ds.

Where was disease contracted, 1219 W. Lofayeth Ave
If not at place of death?

Former or usual residence 1219 W. Lofayeth Ave

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenmount Cem May 13, 1920

20-UNDERTAKER

ADDRESS Orchard

Henry A. Jenkins Orchard
Mr. Cullon

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43045

CERTIFICATE OF DEATH.

D43045

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1211 W. Fayette* ST.; *18* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1211 W. Fayette St.* St. *18* yrs. *14* mos. *14* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

F

4-COLOR OR RACE,

*W.*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Single

6-DATE OF BIRTH,

May, *1873*
(Month) (Day) (Year)

7-AGE,

47 yrs. *14* mos. *14* ds.
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*Maryland*

10-NAME OF FATHER,

*Wesley Day*11-BIRTHPLACE OF FATHER
(State or Country),*Maryland*

12-MAIDEN NAME OF MOTHER

*Margaret Morgan*13-BIRTHPLACE OF MOTHER
(State or Country),*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Victor Day*(Address) *1211 W. Fayette St.*

15-

Filed *MAY 11 1920* *ROBERT E. ERAUTER*Burial *Forest Hill*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May, *10*, *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 9 *1920*, to *May 10* *1920*,
that I saw her alive on *May 9* *1920*,
and that death occurred, on the date stated above, at *12* m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach
& Lungs(Duration) *1* yrs. *3* mos. *3* ds.CONTRIBUTORY
(Secondary)(Duration) *3* yrs. *3* mos. *3* ds.(Signed) *Edward V. Coulahan, M. D.*191... (Address) *74 N. Hollan St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Linden Park Cem.

DATE OF BURIAL,

May 12, 1920

20-UNDERTAKER

Jonas Syfer

ADDRESS

1600 N. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19-H. P. Co. 1900 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43046

CERTIFICATE OF DEATH.

64 D43046

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.: *11* WARD)

2-FULL NAME

(a) RESIDENCE. No. *107 St. Lawrence St.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 11, 1853*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66

8

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Grocer 034

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Thomas Belt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Clara Boone

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Saucer Boone 647 St. Lawrence St.

15

MAY 11 1920

ROBERT B. KRAUTER

Registrar

Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/9/20*

17

I HEREBY CERTIFY, That I attended deceased from

April 29, 19 *May 9*, 19 *20*.

that I last saw him alive on *May 9*, 19 *20*.

and that death occurred, on the date stated above, at *7:30 P.M.*

The CAUSE OF DEATH* was as follows:

Hypertrophic Pulstate

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Yes Date of *May 1, 1920*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Ann S. R. R. R.* M. D.

5/9/20 (Address) *Mary R. R.*

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cem

May 12 1920

20 UNDERTAKER

ADDRESS

Henry W. Jenkins & Co

Richard McCulloch

HEALTH DEPARTMENT—CITY OF BALTIMORE

10-43047

D43047

CERTIFICATE OF DEATH.

104

D43047

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 519 Forrest

ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Salvatore Potera

(Residence in Baltimore: No. 519 Forrest

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Apr 18, 1920

(Month)

(Day)

(Year)

7-AGE,

23

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer)

none

9-BIRTHPLACE,

(State or Country),

Baltimore Md

PARENTS.

10-NAME OF

FATHER,

Pasquale Potera

11-BIRTHPLACE

OF FATHER

(State or Country),

Italy

12-MAIDEN NAME

OF MOTHER

Rosa Fronte

13-BIRTHPLACE

OF MOTHER

(State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Pasquale Potera

(Address)

519 Forrest St

15-

Filed

MAY 11 1920

ROBERT B. KRAUTER

BUPAT FEMT. Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 11, 1920

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 8, 1920, to May 11, 1920,

that I saw him alive on May 10, 1920,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Intoxication

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Exhaustion

(Duration) yrs. mos. ds.

(Signed)

Luigi J. DeStefano

M. D.

May 11, 1920 (Address) 407 W. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Italy Redemptor Center

May 14, 1920

20-UNDERTAKER

ADDRESS

George J. Ruth 1735 Hayford Ave.

D43048

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43048

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1147 Whateoat st ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

James Lagan Muse

(a) RESIDENCE. NO.

1147 Whateoat st ST. _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Cul

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Husband

6 DATE OF BIRTH (month, day, and year)

May 18 1872

7 AGE

Years

Months

Days

If LESS than 1 day, _____ hrs. or _____ min.

48--

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

V. A.

10 NAME OF FATHER

Robert P. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

V. A.

12 MAIDEN NAME OF MOTHER

Mellie Roland

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

V. A.

14

Informant (Address)

Robert P. Johnson
1147 Whateoat st

15

Filed

Robert P. Harrison

Registrar

MAY 11 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 15, 1920, to May 9, 1920.that I last saw him alive on May 8, 1920.and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Industrial RheumatismProbably

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death?

unknownDid an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis?

Microscopic examination(Signed) Thomas Nelson, M. D., 19 _____ (Address) 1001 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

MT Auburn

MAY 12 1920

20 UNDERTAKER

JAMES H. DENNIS

ADDRESS

1303 PRESTMAN ST.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43019

D43019

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 Woodyear ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles Freeman

(a) RESIDENCE. No.

1311 Woodyear ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

No

6 DATE OF BIRTH (month, day, and year)

Nov. 1906

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind.

10 NAME OF FATHER

Albert Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

12 MAIDEN NAME OF MOTHER

Maggie Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind.

PARENTS

14

Informant (Address)

Maggie Freeman
1311 Woodyear St.

15

Filed

19

Registrar

MAY 11 1920

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1920

17

I HEREBY CERTIFY, That I attended deceased from Apr 20, 1920, to May 9, 1920, that I last saw him alive on May 9, 1920, and that death occurred, on the date stated above, at 7 P. m. The CAUSE OF DEATH* was as follows:Myocardial Regurgitation(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No(Signed) William Frey, M. D.5/9, 1920 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mount Auburn

MAY 12 1920

20 UNDERTAKER

JAMES H. DENNIS

ADDRESS

1303 PRESTMAN ST.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D43050

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43050

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital*)ST.: *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Carroll

(a) RESIDENCE. No.

837 Hollins

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>white</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Single</i>
5a If married, widowed, or divorced HUSBAND of (or) WIFE of		

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<i>/</i>	<i>/</i>	<i>27</i>	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Earl O'Leary

11 BIRTHPLACE OF FATHER (city or town) (State or country)

unknown

12 MAIDEN NAME OF MOTHER

Mary Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MD

PARENTS

14 Informant (Address)

E. E. Duncan

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 8 1920*

17 I HEREBY CERTIFY, That I attended deceased from *April 11 1920*, to *May 8 1920*, that I last saw her alive on *May 7 1920* and that death occurred, on the date stated above, at *3:30 a.m.*

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *John W. Harris*, M. D.

5/9, 1920 Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*JOHNS HOPKINS HOSPITAL**May 10 1920*

20 UNDERTAKER

ADDRESS

*Commissioner Health,**E. WOODALL.*

Information should be carefully supplied. Also should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MAY 11 1920

Burial Clerk

D43051

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43051

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital* ST. *12* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Baby Keeney*(a) RESIDENCE. No. *2637 Mace St.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *May 3, 1920*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *1208 E. North*
(State or country)10 NAME OF FATHER *Oscar Lemanski*11 BIRTHPLACE OF FATHER (city or town)
(State or country) *Baltimore, Md.*12 MAIDEN NAME OF MOTHER *Annie Ferman*13 BIRTHPLACE OF MOTHER (city or town)
(State or country) *Davis, Md.*11 Informant *Moore Ferman* JOHNS
(Address) *2637 Mace St.*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 9, 1920*17 I HEREBY CERTIFY, That I attended deceased from
May 3, 1920, to *May 9, 1920*,
that I last saw him alive on *May 9, 1920*,
and that death occurred, on the date stated above, at *8:00 P.* m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical findings*(Signed) *Walter B. Deakins*, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner Health,

MAY 11 1920

Per. Wm. E. WOODALL

Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 11 1920

D43052

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43052

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital. ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Howard(a) RESIDENCE. NO. UnknownST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Unknown</u>
----------------------	---------------------------------	--

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of
Unknown6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE <u>about 68.</u>	Years	Months	Days	If LESS than 1 day, hrs. or min.
<u>Unknown</u>				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) Unknown
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)14 Informant Hospital Records.(Address) New City Hospital.15 Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1920

17 I HEREBY CERTIFY, That I attended deceased from
May 7, 1920, to May 9, 1920
that I last saw him alive on May 9, 1920.
and that death occurred, on the date stated above, at 12:00 A.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Cerebral Hemorrhage)(duration) yrs. mos. ds. 8CONTRIBUTORY Chronic Nephritis
(Secondary)(duration) yrs. mos. ds. 718 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No special tests(Signed) J. P. Parnell M. D.May 9, 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Commissioner Health,

Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 11 1920

MAY 11 1920

D43053

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43053

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1635 N. Caroline* ST.: *8* WARD)2-FULL NAME *Elizabeth E. Schmeltz*(a) RESIDENCE. NO. *1635 N. Caroline* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *60* yrs. mos. ds.How long in U. S., if of foreign birth? *60* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*

5a If married, widowed, or divorced

HUSBAND of *Henry Schmeltz*
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Aug 2/32*7 AGE Years *87* Months *9* Days *8* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant *Geo. W. Blankford*
(Address) *1635 N. Caroline*

15 Robert P. Harrison, Registrar

MAY 11 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 10 1920*

17

I HEREBY CERTIFY, That I attended deceased from *April 15, 1920*, to *May 10, 1920*, that I last saw him alive on *May 9, 1920*, and that death occurred, on the date stated above, at *3 A. M.*

The CAUSE OF DEATH* was as follows:

Chronic Calc. Endocarditis

CONTRIBUTORY (Secondary)

(duration) *Unknown* yrs. mos. ds.(duration) *7* yrs. mos. ds.18 Where was disease contracted if not at place of death? *✓*Did an operation precede death? *No* Date of *✓*Was there an autopsy? *No*What test confirmed diagnosis? *✓*(Signed) *Jefferson Beale, M. D.*
5/11/1920 Address *2844 82 P. Ave. S.E.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Balti Cem.**May 13 1920*

20 UNDERTAKER

ADDRESS

*Philip Herwig**2016 Orleans*

D43054

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43054

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *79* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Anna J. Hanna*(a) RESIDENCE. No. *Reisterstown Md.* ST. *Life* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *Life* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

(or) WIFE of *Warren Hanna*6 DATE OF BIRTH (month, day, and year) *1852*

7 AGE

Years *68*

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*
(State or country) *Maryland*10 NAME OF FATHER *William Jessup*11 BIRTHPLACE OF FATHER (city or town) *Maryland*
(State or country)12 MAIDEN NAME OF MOTHER *J. Bushope*13 BIRTHPLACE OF MOTHER (city or town) *Maryland*
(State or country)

14

Informant (Address) *Hospital Records*
University Hospital

15

MAY 11 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 10 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan. 23, 1920 to May 10, 1920*that I last saw her alive on *May 10, 1920*and that death occurred, on the date stated above, at *9.40 P.M.*

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.(duration) *5* yrs. *0* mos. *0* ds.CONTRIBUTORY (Secondary) *Myocardial insufficiency*(duration) *5* yrs. *0* mos. *0* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical findings.*(Signed) *Laurel Duncan*19 (Address) *University Hospital*

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**May 13 1920*

20 UNDERTAKER

William Cook

ADDRESS

502 E. North Ave

D43055

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43055

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3350 Chestnut Ave ST.: 13 WARD)

2-FULL NAME

(a) RESIDENCE. NO. Pennington Rd.

(Usual place of abode)

ST.

WARD.

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

Life

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofGeo W. Sheridan

6 DATE OF BIRTH (month, day, and year)

March 27

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

57 1 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore
md.

10 NAME OF FATHER

John Kelly

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Louise Shaw

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant

(Address)

Geo W. Sheridan
3350 Chestnut Ave

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 10th 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 27th 1920, to May 10th 1920.that I last saw her alive on May 9th 1920.and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
of the chronic type
duration yrs. mos. ds.CONTRIBUTORY
(Secondary)resulting anaemia
and shock duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of —Was there an autopsy? No

What test confirmed diagnosis?

clinical picture and
urinalysis
(Signed) R. B. Norment M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Marys. RolandMay 12, 1920

20 UNDERTAKER

ADDRESS

Wm Cook502 E North

MAY 11 1920

Information should be carefully supplied. Ages should be stated exactly. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D43056

CERTIFICATE OF DEATH

120 D43056

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 15 S. Linwood Ave

ST.: WARD)

2-FULL NAME

Charles W. Barker

(Residence in Baltimore: No. 15 S. Linwood Ave

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

55 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed

6-DATE OF BIRTH

July 9, 1847

7-AGE

73 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Physician 034
Medical

9-BIRTHPLACE (State or country)

England

PARENTS

10-NAME OF FATHER

Thomas Barker

11-BIRTHPLACE OF FATHER (State or country)

England

12-MAIDEN NAME OF MOTHER

don't know

13-BIRTHPLACE OF MOTHER (State or country)

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Barker
15 S. Linwood Ave

(Address)

MAY 11 1920

Robert P. Harrison,

191
Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 9, 1920

17- I HEREBY CERTIFY, That I attended deceased from

March 1, 1920, to May 9, 1920.

that I saw him alive on May 9, 1920.

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Unknown

Contributory Dilated heart
(SECONDARY)

(Signed) M. J. McAvoy M. D.
May 10, 1920 (Address) 839 S. Ellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery 5/12/1920

20-UNDERTAKER

ADDRESS

J. C. Moran & Baltost

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43052

CERTIFICATE OF DEATH.

88-091
D43052

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 33 04 Clifton Avenue ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ave Maria Drugan

(a) RESIDENCE. NO. 3304 Clifton Avenue ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. 11 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31/1888

7 AGE 31 Years 11 Months 18 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Hugh Drugan

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Annie Barrett

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland14 Informant Vincent P. Drugan
(Address) 605 Electric Bldg. Buffalo, N.Y.

15 Filled Robert P. Harrison, Registrar

MAY 11 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/8/20 19

17 I HEREBY CERTIFY, That I attended deceased from 5/6/20 19, to 5/8/20 19,

that I last saw him alive on 5/8/20 19,

and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Hypothyroidism

(duration) 2 yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) J. H. O. O'Neill, M. D.

, 19 (Address) 1078 West St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

N.Y. Cathedral Cemetery

5/12 19 20

20 UNDERTAKER

ADDRESS

Henry W. Mears & Son 805 W. Calver

St.

D43058

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43058

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Alice Tolson(a) RESIDENCE. No. *1430 Argyle Ave* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

/ yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)*Female Colored Child*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Child*6 DATE OF BIRTH (month, day, and year) *Feb 13 1919*

7 AGE

/ Years

2

Months

Days

If LESS than
1 day, hrs.
or min.*27*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*None*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore Md*

10 NAME OF FATHER

*Albert Tolson*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Baltimore Md*

12 MAIDEN NAME OF MOTHER

*Alice Tucker*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Baltimore Md*

14

Informant
(Address)*Hospital Record*

15

Filed

19

Registrar

MAY 11 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 9 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*Feb 28 1920, to May 9 1920,*that I last saw her alive on *May 9 1920,*and that death occurred, on the date stated above, at *3:35* p. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(duration) yrs. mos. *14* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? *Patent Home*Did an operation precede death? *Yes* Date of *Feb 1920*Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Lee H. Phipps* M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St Peter**5/11/20*

20 UNDERTAKER

Edw Ringgold

ADDRESS

1463 Carey

D43059

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43059

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. *70* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Purcell

(a) RESIDENCE. NO.

3507 E. Baltimore St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

Jan 29 1917

7 AGE

3

Years

3

Months

11

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

William Purcell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Gollie Larson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant (Address)

*Hospital Record**Robert I. Harrison,*

15

Filed

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 9 1920

17

I HEREBY CERTIFY, That I attended deceased from

*April 21, 1920, to May 9, 1920,*that I last saw *deceased* alive on *May 9, 1920,*and that death occurred, on the date stated above, at *6:50 P.M.*

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary)

None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

*home*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Demonstration of tubercle bacilli in spinal fluid*(Signed) *Harold L. Higgins, M.D.*5/10, 1920 Address *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Lawn Cemetery, May 12 1920

20 UNDERTAKER

ADDRESS

Mr. E. Black 927 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

MAY 11 1920

D43060

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43060

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 St Joseph St. ST.: 8 WARD)

2-FULL NAME

(a) RESIDENCE. No. 1114 St Joseph St. ST.: 8 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1920

17

I HEREBY CERTIFY, that I attended deceased from

April 14, 1920, to May 10, 1920.

that I last saw him alive on May 9, 1920.

and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

CONTRIBUTORY (duration) yrs. mos. ds.

Arterio Sclerotic Brain

Secondary (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Phys. & Microscopic

(Signed) H. G. Harrison, M. D.

5/10/1920 Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Arnold Station May 13, 1920

20 UNDERTAKER

ADDRESS

Leo G. Crook

1114 St Joseph St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

MAY 11 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43061

CERTIFICATE OF DEATH.

D43061

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1540 N. Fulton Ave.* ST.: *15* WARD)

2-FULL NAME

(a) RESIDENCE. No. *1540 N. Fulton Ave.* ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *32* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Sallie L. Durben

6 DATE OF BIRTH (month, day, and year)

July 29, 1866

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*53**9**12*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Proprietor of

(b) General nature of industry, business, or establishment in which employed (or employer)

Boulevard Laundry

(c) Name of employer

Fred Co. Md

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Philip Durben

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Penna

12 MAIDEN NAME OF MOTHER

Susan Kline

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant

(Address)

*Miss Sallie L. Durben**1540 N. Fulton Ave*

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 11 1920*

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 29, 1920*, to *May 11, 1920*.that I last saw him alive on *May 11, 1920*.and that death occurred, on the date stated above, at *5:35 A.* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach(duration) yrs. *6* mos. ds.CONTRIBUTORY *Metastasis in liver*(Secondary) (duration) yrs. *2* mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *yes* Date of *March 1, 1920*Was there an autopsy? *no*What test confirmed diagnosis? *Operation + microscope*(Signed) *James C. Thompson, M. D.*May 11, 1920 (Address) *818 Park Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cem. *May 14 1920*

20 UNDERTAKER

ADDRESS *1944**Harry W. Ehlen* *W. North Ave*

MAY 11 1920

D43062

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43062

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 W. Saratoga ST.; 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thomas Batson(a) RESIDENCE. No. 1827 W. Saratoga ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22, 18477 AGE Years 74 Months 9 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Dayton (State or country) Ohio10 NAME OF FATHER Martin H. Batson11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)12 MAIDEN NAME OF MOTHER Mary Tyles13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)14 Informant Dr. M. J. Hanna (Address) 1827 W. Saratoga St.15 Filed May 11 1920 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 192017 I HEREBY CERTIFY, That I attended deceased from May 6, 1920, to May 10, 1920, that I last saw him alive on May 10, 1920, and that death occurred, on the date stated above, at 6:57 m.

The CAUSE OF DEATH* was as follows:

Acute Traumatic(duration) yrs. mos. 5 ds.CONTRIBUTORY Ch. Pneumonia (Secondary) Keptitis (duration) 2 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? (Signed) Paul Brown M. D.5/11, 1920 Address 1837 Penna. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Western May 12 1920

20 UNDERTAKER ADDRESS

Robert S. Little 531 N. Fremont Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D43063

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Aloysius Kalisch* ST.; *15* WARD)

2-FULL NAME

(Residence in Baltimore: No. *11* St.; *20* yrs., *0* mos., *0* ds.)REGISTERED No. C *D43063*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word)

Married

6-DATE OF BIRTH

Aug 5/74

7-AGE

46

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

*Mrs. Edna Kalisch**3208 Garrison Ave.*

15-

*MAY 11 1920**Robert P. Harrison,**Burial Permit Clerk,*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 11

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr 5 1920, to *May 11 1920*,that I saw him alive on *May 11 1920*, and that death occurred, on the date stated above, at *2 P* m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Spleen with Pernicious Anemia

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

None apparent

(Signed)

Chas. S. Parker M. D. *5/11*, 1920 (Address) *3123 W. North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore

DATE OF BURIAL,

May 13 1920

20-UNDERTAKER

Robert S. Little

ADDRESS

531 N. Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43061

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43061

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (NO. Bay View Hospital ST. 26 WARD)

2-FULL NAME

Edward J. Murphy(Residence in Baltimore: No. 3426 Mt. Pleasant Ave St. 17, mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH

September 13, 1880
(Month) (Day) (Year)

7-AGE

357 yrs. 27 mos. 27 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Halvor 0409-BIRTHPLACE,
(State or Country).Cincinnati Ohio10-NAME OF
FATHERFrank Murphy11-BIRTHPLACE
OF FATHER
(State or Country).Ireland12-MAIDEN NAME
OF MOTHERMary Wallace13-BIRTHPLACE
OF MOTHER
(State or Country).Balt. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Andrew Winkam

(Address)...

3426 Mt. Pleasant Ave

15-

1 1920Robert P. Harrison,Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 9, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest autopsy inquiry.
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest autopsy inquiry.
(Inquest, au-topsy or inquiry.) find that said deceased came to death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Bright Disease

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Harry Spaul Coroner

M. D.

1911 (Address) 1610 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn

DATE OF BURIAL,

May 12, 1920

20-UNDERTAKER

William Cook

ADDRESS

502 E. North Ave

D43065

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43065

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 8th St. ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1010 8th St.

(Usual place of abode)

ST. 26 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of John S. Holbrook6 DATE OF BIRTH (month, day, and year) Dec 15 18627 AGE Years 57 Months 4 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cardonia Cr (State or country) Md10 NAME OF FATHER John Butler11 BIRTHPLACE OF FATHER (city or town) (State or country) Md12 MAIDEN NAME OF MOTHER Mary Christopher13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14

Informant (Address) John S. Holbrook
1010 S. 3rd St.

15

Filed

19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1920

17

I HEREBY CERTIFY, That I attended deceased from May 10, 1920, to May 15, 1920, that I last saw him alive on May 15, 1920, and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Ascending Pulmonary
Edema (duration) yrs. mos. ds.
CONTRIBUTORY Chronic Myocarditis
(Secondary) Chronic (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Wright Dwyer M. D.(Address) 3423 E. Paul St

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Mc-Cormac
4 m CorkMay 13 1920
H. V. G. H. G.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 11 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43066

CERTIFICATE OF DEATH.

79 D43066

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 E. Barney ST.; 24 WARD)

2-FULL NAME

(a) RESIDENCE. No. 501 E. Barney ST.; 24 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widower5a If ~~married~~, widowed, ~~divorced~~, ~~or~~ HUSBAND of Mary E. Conroy.6 DATE OF BIRTH (month, day, and year) July 6, 18527 AGE Years 67 Months 10 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Cabinet Maker.(b) General nature of industry, business, or establishment in which employed (or employer) Not employed(c) Name of employer Not employed9 BIRTHPLACE (city or town) Ireland.
(State or country)10 NAME OF FATHER Thomas J. Conroy.11 BIRTHPLACE OF FATHER (city or town) Ireland.
(State or country)12 MAIDEN NAME OF MOTHER Anne Dunn13 BIRTHPLACE OF MOTHER (city or town) Ireland.
(State or country)14 Informant Mrs. Annie Daniels
(Address) W. Demere, Del.15 Filed Robert P. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 192017 I HEREBY CERTIFY, That I attended deceased from April 10, 1920, to May 9, 1920, that I last saw him alive on May 9, 1920, and that death occurred, on the date stated above, at 1.30 P. m.
The CAUSE OF DEATH* was as follows:Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)(duration) 3 yrs. mos. ds.18 Where was disease contracted At home.
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical signs(Signed) Sidney H. Street, M. D.5/10, 1920 (Address) 405 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 11 1920

D43067

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43067

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3415 Cedar Ave ST. 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 3415 Cedar Ave St. 91 yrs., 4 mos., 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH,

Dec 29, 1829
(Month) (Day) (Year)

7-AGE,

91 yrs., 4 mos., 18 ds.

If LESS than 1 day.

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Balto Co. State of Maryland

10-NAME OF FATHER,

Joseph Morris

11-BIRTHPLACE OF FATHER (State or Country),

Balto Co.

12-MAIDEN NAME OF MOTHER

Fernina Brown

13-BIRTHPLACE OF MOTHER (State or Country),

Balto Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Edward F. Edgington(Address) 3415 Cedar Ave

15-

Robert P. Harrison,

Filed

191

MAY 11 1920

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5-10, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 26 1920, to May 10 1920, that I saw her alive on May 9 1920, and that death occurred, on the date stated above, at 5:49 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis(Duration) 2 yrs., 15 mos., 15 ds.

CONTRIBUTORY (Secondary)

Fractured Hip(Duration) 15 yrs., 15 mos., 15 ds.(Signed) Chas. A. Conklin M. D.5-10, 1920 (Address) 3781 R. 1st Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 91 yrs., 4 mos., 18 ds. In the State 91 yrs., 4 mos., 18 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Parkton Md

DATE OF BURIAL,

May 12 1920

20-UNDERTAKER

E. Roy Sipple

ADDRESS

1258 North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43068

D43068

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *German aged Home*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *German aged Home*)St.; *1st* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*Wt.*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *Single*

6-DATE OF BIRTH.

August 1st, 1836
(Month) (Day) (Year)

7-AGE,

*83 yrs. 9 mos. 9 ds.*If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*Harford Co. Md.*

10-NAME OF FATHER,

*James Russell*11-BIRTHPLACE OF FATHER
(State or Country),*Md.*

12-MAIDEN NAME OF MOTHER

*Martha Miller*13-BIRTHPLACE OF MOTHER
(State or Country),*Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Records German aged Home*(Address) *Balt. and Payson Sts.*

15-

Robert P. Harrison,

MAY 11 1920

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 10th, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Dec 10, 1919*, to *May 10th, 1920*, that I saw her alive on *May 8th, 1920*, and that death occurred, on the date stated above, at *8:30 a.m.*
The CAUSE OF DEATH* was as follows:*Chronic Nephritis*(Duration) *1 yrs. mos. ds.*CONTRIBUTORY
(Secondary)(Duration) *.... yrs. mos. ds.*(Signed) *John H. Hauff, M. D.*
May 10, 1920 (Address) *1143 W. Baltimore St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *5* yrs. *....* mos. *....* ds. In the State *....* yrs. *....* mos. *....* ds.

Where was disease contracted, if not at place of death?

Former or usual residences

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Westview Cem.**May 12th, 1920*

20-UNDERTAKER

ADDRESS

*Joseph B. Cook**1003 11th St. Balt. Md.*

D43069

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43069

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 W Lammale ST.; 16 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 1626 W Lammale St.; 18 yrs., 7 mos., 14 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb. 16, 1862
(Month) (Day) (Year)

7-AGE, 58 yrs., 7 mos., 14 ds.
If LESS than 1 day,hrs. ormin.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) v3

9-BIRTHPLACE, (State or Country), Baltimore Md

10-NAME OF FATHER, Edward H Beefelt

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Rose Theresa Henkel

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Parker(Address) 1626 W Lammale St15- Robert P. Harrison,

MAY 11 1920

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 5 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 3rd 1920, to May 10 1920, that I saw h- alive on May 10 1920, and that death occurred, on the date stated above, at 6:40 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Duration).....yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary).....
(Duration).....yrs.mos.ds.

(Signed) W. H. Phillips M. D.
5-10-20, 1920 (Address) 2539 Edmonson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.mos.ds. In the State.....yrs.mos.ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western CoDATE OF BURIAL, May 13, 192020-UNDERTAKER Joseph J CookADDRESS 1003 W Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43070

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43070

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Josephs Hosp* ST.: *9* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Margaret Russell

(a) RESIDENCE. NO.

Leonardtown Md

WARD.

Leonardtown Md

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

15

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

— 1885

7 AGE

Years

Months

Days

30

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wg

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Leonardtown Md

10 NAME OF FATHER

P

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Leonardtown

12 MAIDEN NAME OF MOTHER

P

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

P

14

Informant (Address)

Chas Russell Leonardtown Md

15

MAY 12 1920

ROBERT A TRAUTE

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 11* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

April 26, 19*20*, to *May 11*, 19*20*,

that I last saw her alive on *May 11*, 19*20*,

and that death occurred, on the date stated above, at *9 P* m.

The CAUSE OF DEATH* was as follows:

Myocardial Infarction

(duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

Anemia (duration) yrs. *7* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Latrnatung*

(Signed) *J.T. O'Connell*, M. D.

, 19 (Address) *St Josephs Hosp*

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Leonardtown Md

5-13 1920

2 UNDERTAKER

Robt Brooks & Son

ADDRESS *Calhoun & Hollins St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1909 Bks.

D43071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1302 Webb*)

ST. *10* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *1302 Webb*

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed,
or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jul 15, 1920

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

2

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

None

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

Julius Dexter

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Willa Nash

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Virginia

14

Informant
(Address)

*Julius Dexter
1302 Webb St*

15

Filed *MAY 12 1920*

ROBERT R. LEAUTE
Registrar

Burial Permit *0107*

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

104

D43071

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 10 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 9 1920 to *May 10 1920*

that I last saw him alive on *May 10 1920*

and that death occurred, on the date stated above, at *10 P. m.*

The CAUSE OF DEATH was as follows:

*Diarrhea and Enteritis
(cause) probably
feeding a little
infant.*

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Dr. Garland* M. D.

(Address) *1534 E. H. Ave*

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Interment lot

DATE OF BURIAL

May 12 1920

20 UNDERTAKER

Mrs. R. A. G. Hunt

ADDRESS

1721

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43072

CERTIFICATE OF DEATH.

79
REGISTERED NO.

D43072

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 S. Bentalow ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Leroy W. Voller

(a) RESIDENCE. NO.

536 S. Bentalow ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 7 mos. 19 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 23rd 1904

7 AGE

Years

Months

Days

If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk009

(b) General nature of industry, business, or establishment in which employed (or employer)

Shirt Factory

(c) Name of employer

Oppenheimer & Co.

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Mr. F. Voller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Rosie Hendel

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

14

Informant (Address)

Mr. F. Voller
536 S. Bentalow St.

15

Filed

MAY 12 1920

ROBERT R. KRAUTER

Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 11 1920

17

I HEREBY CERTIFY, That I attended deceased from May 3, 1920, to May 11, 1920, that I last saw him alive on May 11, 1920, and that death occurred, on the date stated above, at 5:45 a. m.

The CAUSE OF DEATH was as follows:

Acute Papuleyematous Nephritis
Endocarditis(duration) 1 week mos. ds.

CONTRIBUTORY (Secondary)

Juliusburg, Odenburg

Where was disease contracted if not at place of death?

Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert C. Putnam, M. D.(Address) 2151 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery May 14 1920

20 UNDERTAKER

ADDRESS

H. R. Shipper 2236 Frederick Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43073

CERTIFICATE OF DEATH.

170 D43073
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Francis Square Hospital* ST. *170* WARD)

2-FULL NAME

(Residence in Baltimore: No. *3201 Brighton* St. *170* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

m

4-COLOR OR RACE

m

5-SINGLE

Widowed

WIDOWED

OR DIVORCED

(Write the word)

6-DATE OF BIRTH,

February 23, 1847
(Month) (Day) (Year)

7-AGE,

73 yrs. 2 mos. 10 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Retired*9-BIRTHPLACE,
(State or Country),*Balto. City*

10-NAME OF FATHER,

*John Thomas Krug*11-BIRTHPLACE OF FATHER
(State or Country),*Don't Know*

12-MAIDEN NAME OF MOTHER

*Rosina Haas*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Stephen Krug

(Address)

4015 Edmond

15-

ROBERT R. KRAUTER

MAY 12 1920

191. BUYING FROM STATE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 10, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*April 18, 1920, to May 10, 1920,*that I saw him alive on *May 10, 1920,*and that death occurred, on the date stated above, at *7:40 P.M.*

The CAUSE OF DEATH* was as follows:

Chronic nephritis
arteriosclerosis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)*Cerebral apoplexy*
(Duration) ... yrs. ... mos. ... ds.(Signed) *Chas. Jones* M. D.*May 10, 1920* (Address) *2802 Rodgman*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. *30* ds. In the State *Life* mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

3201 Brighton St

19-PLACE OF BURIAL OR REMOVAL,

Baltimore

DATE OF BURIAL,

May 13, 1920

20-UNDERTAKER

H. Sander & Sons

ADDRESS

1710 Fleet St

CAUSE OF DEATH in plain terms, so that it may be properly translated. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D43071

CERTIFICATE OF DEATH

81 D43071
REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 6 Beechwood Ave ST. 27 WARD)

FULL NAME

(Residence in Baltimore: No. 6 Beechwood Ave St. 27 yrs. 81 mos. 17 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE married
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH April 22, 1839
(Month) (Day) (Year)

7 AGE 81 yrs. 17 ds. or min.?
If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work Gardner etc.
(b) General nature of industry, business, or establishment in which employed (or employer) 886

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Edward Mepham

11 BIRTHPLACE OF FATHER (State or country) England

12 MAIDEN NAME OF MOTHER Burnett Woolen

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary E Mepham

(Address) 6 Beechwood Ave

15. MAY 12 1920

ROBERT E KAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 9th, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 5th, 1920, to May 9th, 1920, that I saw him alive on May 9th, 1920, and that death occurred, on the date stated above, at 11:45 P.M. The CAUSE OF DEATH* was as follows:

hypostatic Pneumonia.

Contributory (SECONDARY) General Arterio Sclerosis
(Duration) yrs. mos. ds.

(Signed) Samuel Zimmerman M. D.
May 11th, 1920 (Address) 1805 W North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Linden Park DATE OF BURIAL May 12, 1920

20 UNDERTAKER Josiah Sydnor ADDRESS 1600 W North Ave

D43075

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D43075

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 W West ST.; 21 WARD)2-FULL NAME Laurance J. Healey(a) RESIDENCE. No. 417 W West ST., 21 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 19 19197 AGE Years Months Days If LESS than 1 day, hrs. or min. 11 22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto10 NAME OF FATHER Laurance Healey11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto12 MAIDEN NAME OF MOTHER Ethel Healey13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD14 Informant Laurance Healey (Address) 417 W West St15 MAY 12 1920 ROBERT B. BLANTER

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 192017 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to May 11, 1920, that I last saw him alive on May 10, 1920, and that death occurred, on the date stated above, at 3 A.m. The CAUSE OF DEATH* was as follows:Gastro EnteritisCONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 11 ds. (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical Symptom (Signed) R. D. Campbell, M. D.0/2/1920 (Address) 1649 Hancock

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cem

DATE OF BURIAL

April 13 1920

20 UNDERTAKER

M. S. Flynn

ADDRESS

1649 Hancock

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D43076

PLACE OF DEATH

64 ✓
REGISTERED NO. C

D43076

CITY OF BALTIMORE (No. *2657 N. North Ave* ST. *15* WARD)

2. FULL NAME *Johanna Cummings*

(Residence in Baltimore: No. *2657 N. North Ave* St. *13* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widowed

6 DATE OF BIRTH

Jan 13, 1846
(Month) (Day) (Year)

7 AGE

74 yrs. *3* mos. *28* ds. or min.?

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

House Keeper
800

9 BIRTHPLACE (State or country)

Ireland

PARENTS

10 NAME OF FATHER

William Heaphy

11 BIRTHPLACE OF FATHER (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Johanna Hargan

13 BIRTHPLACE OF MOTHER (State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. J. Cummings

(Address)

2657 N. North Ave

15 MAY 12 1920

ROBERT E. KAUTER

Filed

191

Sanitary Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 10, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 30, 1920, to *May 10*, 1920.

that I saw her alive on *May 10*, 1920.

and that death occurred, on the date stated above, at *9:30* m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. *10* ds.

Contributory (SECONDARY)

Paralysis

(Duration) yrs. mos. *10* ds.

(Signed)

Herbert E. Zapp M. D.

May 11, 1920 (Address) *3850 N. North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

New Cathedral Cem

DATE OF BURIAL

May 14, 1920

20 UNDERTAKER

Mc Doyle

ADDRESS

15 E. Lee St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *119 W. Barre* ST. *22* WARD)2-FULL NAME *Charles E. Bain*(a) RESIDENCE. No. *119 W. Barre* ST. *22* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *4* yrs. — mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Rose M. Bain*6 DATE OF BIRTH (month, day, and year) *April 23 - 1867*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*53**17*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Danison Chem Co*9 BIRTHPLACE (city or town)
(State or country)*Pa*

10 NAME OF FATHER

John Bain

11 BIRTHPLACE OF FATHER (city or town)

md

(State or country)

12 MAIDEN NAME OF MOTHER

Mary Vernon

13 BIRTHPLACE OF MOTHER (city or town)

Pa

(State or country)

14

Informant

(Address)

*Rose M. Bain**119 W. Barre St*

15

F. A. Brance & Son

*MAY 12 1920**ROBERT E. FRANKLIN*
Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *11 May 1920*

17

I HEREBY CERTIFY, That I attended deceased from

2 April 1920, to *10 May 1920*,that I last saw him alive on *10 May 1920*,and that death occurred, on the date stated above, at *10 p* m.

The CAUSE OF DEATH* was as follows:

chronic valvular heart disease -(duration) — yrs. *8* mos. — ds.CONTRIBUTORY
(Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *John H. Brown* M. D., 19 (Address) *602 S. Penn St. Baltimore*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Chambersburg Pa**May 13 1920*

20 UNDERTAKER

ADDRESS

F. A. Brance & Son 103 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43078

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓ D43078

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2232 Eting ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Alexander Sheridan(a) RESIDENCE. NO. 2232 Eting
(Usual place of abode)

ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE C 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofLydia Sheridan

6 DATE OF BIRTH (month, day, and year)

18797 AGE Years Months Days If LESS than 1 day, hrs. or min.
41 — — — — — —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Job - Plaster

(b) General nature of industry, business, or establishment in which employed (or employer)

057

(c) Name of employer

hlf.9 BIRTHPLACE (city or town)
(State or country)Ind.

10 NAME OF FATHER

Alex. Sheridan11 BIRTHPLACE OF FATHER (city or town)
(State or country)Ind.

12 MAIDEN NAME OF MOTHER

Mary Waller13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Ind.

14

Informant
(Address)Lydia Sheridan
2232 Eting

15

FEB

MAY 12 1920

ROBERT E. KRAUTER

Registrar

Basis Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10 1920

17

I HEREBY CERTIFY, That I attended deceased from

3/15, 1920, to 5/10, 1920,that I last saw him alive on 5/10, 1920,and that death occurred, on the date stated above, at 11:20 p. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. R. C. Butler, M. D., 19 (Address) 137 Grand St. N. W.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Int. from CountryMay 12 1920

20 UNDERTAKER

ADDRESS

Mrs. Robert A. E. Ashland

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43079

CERTIFICATE OF DEATH.

50

D43079

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 N. Patterson Park Ave. ST.:

WARD) 6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Jacob Hofmeister

(a) RESIDENCE. NO.

12 N. Patterson Park Ave.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Barbara Hofmeister

6 DATE OF BIRTH (month, day, and year)

May 16-1847

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

76

11

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired 15 years

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Germany

10 NAME OF FATHER

John Hofmeister

11 BIRTHPLACE OF FATHER (city or town)

Germany

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)

Not known

14

Informant

(Address)

Barbara Hofmeister
12 N. Patterson Park Ave

15

MAY 12 1920

ROBERT E. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 9th 1920

17

I HEREBY CERTIFY, That I attended deceased from

1920, to May 1920.

that I last saw him alive on May 1920.

and that death occurred, on the date stated above, at 9¹⁰ A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Cherry, M. D.

(Address) 647 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lorraine Cemetery

May 12 1920

20 UNDERTAKER

H. San der Louw

ADDRESS

1710 N. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43080

CERTIFICATE OF DEATH.

151 D43080

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 S. Robinson St. ST.; 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Martin Pilschowski.

(a) RESIDENCE. No.

17 S. Robinson St.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

4 mos.

27 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec. 15-1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

John Pilschowski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Anna Stadter

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md.

14

Informant (Address)

John Pilschowski.
17 Robinson St.

15

Filed

MAY 12 1920

ROBERT B. TRAUBER

Burial Permit

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1920

17

I HEREBY CERTIFY, that I attended deceased from March 15, 1920, to May 11, 1920, that I last saw him alive on " 10, 1920,

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Mal. Nutrition

CONTRIBUTORY (Secondary)

Convulsions

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) G. A. Zuer M. D.

, 1920 Address 408 Spatterton Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cem.

May 12 1920

20 UNDERTAKER

Lilly and Zeller

ADDRESS

403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D43081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

108 D43081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William A. Woods

(a) RESIDENCE, No.

St. Helena

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofMrs M. Woods

6 DATE OF BIRTH (month, day, and year)

1888

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.32

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Careaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Va.

10 NAME OF FATHER

B H Wood

11 BIRTHPLACE OF FATHER (city or town)

Va.

(State or country)

12 MAIDEN NAME OF MOTHER

C Wilson

13 BIRTHPLACE OF MOTHER (city or town)

Va.

(State or country)

14

Informant
(Address)University Data
Bureau & Lombard

15

Filed

MAY 12 1920ROBERT E. KAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 10 19 20

17

I HEREBY CERTIFY, That I attended deceased from

4/22, 19 20, to 5/10, 19 20,that I last saw him alive on 5/10, 19 20,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction(duration) yrs. mos. 3 ds.CONTRIBUTORY
(Secondary)Suppurative AppendicitisPeritonitis (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

St Helena

Did an operation precede death?

Yes Date of 4/23 to 5/9/20

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

C O Perlschneider, M. D.

5/10, 1920 (Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cal. Lawn Cem.

DATE OF BURIAL

May 13 19 20

20 UNDERTAKER

Lilly and Ziehl

ADDRESS

403 S. BroadwayW 1433

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec. 6-9-19-H. P. Co. 1000 Bks.

D43082

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43082

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital 26* WARD)

2-FULL NAME *Edwin M. Westerson - Jr.*

(a) RESIDENCE. NO. *3522 N. Pleasant Ave.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *2 1/2* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct 24 - 1919*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *6 19*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Md.*

10 NAME OF FATHER *Edwin M. Westerson*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *Md.*

12 MAIDEN NAME OF MOTHER *John M. Warden*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *Md.*

14 Informant *J. H. Beards* (Address)

15 MAY 12 1920

ROBERT R. KAUTER Registrar
Bureau of Health

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 11th* 19 *20*

17 I HEREBY CERTIFY, That I attended deceased from *May 10, 1920, to May 10, 1920,* that I last saw him alive on *May 10, 1920,* and that death occurred, on the date stated above, at *10 40 p. m.* The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. *14* ds.

CONTRIBUTORY *Subcutaneous em-* (Secondary) *physema* (duration) yrs. mos. *2* ds.

18 Where was disease contracted *home* If not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Autopsy* (Signed) *Harold E. Heggins* M. D.

Johns Hopkins Hosp 5/11 1920 Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Ave

May 17 1920

20 UNDERTAKER

ADDRESS

John DeBick

2008 Alameda

D43083

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43083

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Church Home and Infirmary.

REGISTERED NO.

CITY OF BALTIMORE: (No.

N. Broadway

ST.: 9th E. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Miss Mary Morewood

(a) RESIDENCE. NO.

925 E. Hoffman St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 21-1905

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

15

1

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School

(b) General nature of industry, business, or establishment in which employed (or employer)

Girl

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Geo Morewood

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mary Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant

(Address)

Mary Morewood

1208 N. Valley St.

15

MAY 12 1920

ROBERT E. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 10, 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 4, 1920, to May 10, 1920.

that I last saw her alive on May 10, 1920.

and that death occurred, on the date stated above, at 11⁴⁰ P.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of kidney, left

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 10, 1920

Was there an autopsy? no

What test confirmed diagnosis? Confirmed at op.

(Signed) Walter T. Anderson M. D.

19 (Address) Church Home and Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral

May 14 1920

20 UNDERTAKER

ADDRESS

H. C. Wiedefeld

914 Thimble Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43081

CERTIFICATE OF DEATH.

D43081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 E. FederalST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1709 E. Federal

(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

20 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

20 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofMary Katherine Lafferty

6 DATE OF BIRTH (month, day, and year)

Sept. 12, 1859

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.66728

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Ireland

10 NAME OF FATHER

John Lafferty11 BIRTHPLACE OF FATHER (city or town)
(State or country)Ireland

12 MAIDEN NAME OF MOTHER

Elizabeth Voth13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Ireland

14

Informant
(Address)Thos. Melio Van Rossum
1709 E. Federal St.

15

Filed

MAY 12 1920ROBERT E. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May, 10, 1920

17

I HEREBY CERTIFY, That I attended deceased from
May 4, 1920 to May 10, 1920that I last saw him alive on May 19, 1920and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sandroek M. D., 19 (Address) 1601 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore

DATE OF BURIAL

May 13 1920

20 UNDERTAKER

Wendell Dwyer & Son

ADDRESS

378 N.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43086

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

54 D43086

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 421 S Ann ST, 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Paul

(Residence in Baltimore: No. 421 S Ann St.; 50 yrs., c mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH,

April 7, 1866
(Month) (Day) (Year)

7-AGE,

54 yrs., 1 mos., 4 ds.

If LESS than 1 day,
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).Housework
at home9-BIRTHPLACE,
(State or Country),

St Louis

10-NAME OF
FATHER,

John Hacker

11-BIRTHPLACE
OF FATHER
(State or Country),

Ill

12-MAIDEN NAME
OF MOTHER

Marie Hacker

13-BIRTHPLACE
OF MOTHER
(State or Country),

Ill

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Henry Paul

(Address) 421 S Ann St

15-

MAY 12 1920
ROBERT B. RAUTER
Baltimore Health Department Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5 11, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Jan 1 1920, to 5-11 1920,
that I saw him alive on 5-11 1920,
and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Pericarditis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY... Asthma & Bronchitis

(Secondary)

(Duration) yrs. mos. 2 ds.

(Signed) J. A. Paul

5-12, 1920 (Address) 1623 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS-
IENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Carmel

May 14, 1920

20-UNDERTAKER

ADDRESS

Peter Nicolaus

2046 Eastern

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43087

CERTIFICATE OF DEATH.

79

D43087

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

807 S Lakewood Ave 1st

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Louise Radtka

(Residence in Baltimore: No.

807 S Lakewood Ave St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Widow

6-DATE OF BIRTH,

Aug 7, 1885
(Month) (Day) (Year)

7-AGE,

84 yrs. 9 mos. 3 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

at home

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Ger

12-MAIDEN NAME OF MOTHER

Louise Hoefl.

13-BIRTHPLACE OF MOTHER (State or Country),

Ger

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Ed. Radtka

(Address)

807 S Lakewood Ave

15-

MAY 12 1920

ROBERT D. RAUTER

Filed 191.

BALTIMORE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 10, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from May 7, 1920, to May 10, 1920, that I saw him alive on May 7, 1920, and that death occurred, on the date stated above, at 10:15 p.m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) 1 yrs. mos. ds.

CONTRIBUTOR (Secondary)

Valerius D. Hart

(Duration) 1 yrs. mos. ds.

(Signed) Chas. J. Heer M. D.
5/11/20 (Address) 408 S. Pat. Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

1st German

DATE OF BURIAL.

May 13, 1920

20-UNDERTAKER

Peter Nicolaus

ADDRESS

2046 Eastern Ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43088

CERTIFICATE OF DEATH.

D43088

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3604 Hooper Ave ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 3604 Hooper Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

May 7 - 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Helen Lizer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Sound Ruby

JOHNS HOPKINS HOSPITAL

15

MAY 12 1920

ROBERT B. ELLIOTT Registrar

Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1920

17

I HEREBY CERTIFY, That I attended deceased from May 7th, 1920, to May 11, 1920, that I last saw him alive on May 10th, 1920, and that death occurred, on the date stated above, at 9.00 P. M. The CAUSE OF DEATH* was as follows:

Congenital Atresia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) B. G. Linder M. D.

9/2, 1920 (Address) 1427 Union Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Commissioner Health,

Rev. W. E. WOODALL

ADDRESS

MAY 12 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43089

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2516 Ashland ST. 7 WARD)

2-FULL NAME

Annie Loretta Bullen(a) RESIDENCE. No. 2516 Ashland ST. 7 WARD.
(Usual place of abode)Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 12/1920

7 AGE

Years

Months

Days

If LESS than
1 day, 9 hrs.
or 00 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Balto. Ind.

10 NAME OF FATHER

James L. Bullen11 BIRTHPLACE OF FATHER (city or town)
(State or country)Balto. Ind.

12 MAIDEN NAME OF MOTHER

Mary E. Kelly13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Balto. Ind.

14

Informant
(Address)James L. Bullen
2516 Ashland av.

15

File

MAY 12 1920ROBERT K. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 12 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 12 20 to May 12 20that I last saw him alive on May 12, 19 20

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

Address

John J. Luecke M. D.
2958 Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

H. Mary's Graves,5/12 1920

20 UNDERTAKER

J. A. Moran

ADDRESS

3000 E. Balto.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

D43090

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43090

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 23 E. Church St.

St. 22 WARD)

2-FULL NAME John Mason. (C).

(Residence in Baltimore: No. 23 E. Church St.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

10 -----
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, Colored. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widower. (Write the word.)

6-DATE OF BIRTH, Do not know. 1
(Month) (Day) (Year)

7-AGE, 49 yrs. --- mos. --- ds. If LESS than 1 day, --- hrs. or --- min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS. 10-NAME OF FATHER, Do not know. 11-BIRTHPLACE OF FATHER (State or Country), Do not know. 12-MAIDEN NAME OF MOTHER, Do not know. 13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) John Turner. (C). (Address) 23 E. Church St.

15- Robert P. Harrison, UNIVERSITY OF MARYLAND. Filed 12 1920. 191. Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 4th, 1920. 191
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry. (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) M. D. (Coroner.)

May 5th, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL, May 12, 1920

20-UNDERTAKER ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43091

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Mt Hope Reheat

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Helen A. Stewart

(a) RESIDENCE. NO.

Mt Hope Reheat

ST.:

28th

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White

Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

57 —

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home duties 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Lancaster Penna

10 NAME OF FATHER

Daniel A. Allick

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Lancaster Pa

12 MAIDEN NAME OF MOTHER

Mary Graef

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Lancaster Pa

14

Informant (Address)

Records of Mt Hope Reheat Baltimore Md

15

Filed

Robert P. Harrison

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 11th 1920

17

I HEREBY CERTIFY, That I attended deceased from

Dec 11th 1918

to

May 11

1920

that I last saw her alive on

May 11

1920

and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis - Progressive -

asth

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Chor Melancholia -

Post Menopausal

(duration) 2 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Lancaster Pa

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Frank J. Lannery

M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lancaster - Pa

May 12/1920

20 UNDERTAKER

STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 12 1920

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43092

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43092

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Hollins Market* ST. *16* WARD)

2-FULL NAME *Samuel J. Williams*

(Residence in Baltimore: No. *2328 Edmonson Ave* St.: yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *male*

4-COLOR OR RACE *white*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH, *Mar 20, 1866*

7-AGE, *54* yrs. *1* mos. *12* ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Common*
(b) General nature of industry, business, or establishment in which employed (or employer). *Merchant*

9-BIRTHPLACE, (State or Country), *Md & C*

10-NAME OF FATHER, *Jessie Williams*

11-BIRTHPLACE OF FATHER (State or Country), *Maryland*

12-MAIDEN NAME OF MOTHER *Kecis*

13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Cashier Williams*

(Address) *2328 Edmonson Ave*

15-

Robert P. Harrison,

Registration
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 12, 1920*

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*, and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) *6* yrs. *6* mos. *6* ds.
CONTRIBUTORY *acute dilatation*
(Secondary) *of heart*

(Signed) *James M. Fenton* M. D.
(Coroner.)
May 12 1920 (Address) *700 Chase St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, *54* yrs. *1* mos. *12* ds. In the State, *54* yrs. *1* mos. *12* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park Cemetery*

DATE OF BURIAL, *May 15, 1920*

20-UNDERTAKER, *STEWART & MOWEN COMPANY*
(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AV

MAY 12 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43093

D43093

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, NO.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Filed

191

Robert P. Harrison,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 7 1920, to May 10 1920,

that I saw him alive on May 10 1920,

and that death occurred, on the date stated above, at 2:50 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Valv. Heart Dis.

From history 3 weeks

CONTRIBUTORY Imp. condition

(Signed) E. J. Thirlington M. D.

5.10.1920 (Address) 100 E. Fort Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Western Cemetery

May 13, 1920

20-UNDERTAKER

ADDRESS

Robt J. Turner

1412 N. Broadway

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43091

D43091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Argyle Ave. ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Forbes(Residence in Baltimore: No. 1606 Argyle Ave. St.; 3 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Unknown, 1892
(Month) (Day) (Year)

7-AGE,

27+ yrs. + mos. + ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business,

or establishment in which

employed (or employer).

Domestic
servant

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE

OF FATHER
(State or Country).Unknown

12-MAIDEN NAME

OF MOTHER

Unknown

13-BIRTHPLACE

OF MOTHER
(State or Country),Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Freeman Robins(Address).....1606 Argyle Ave.

15-

Robert P. Harrison,

MAY 12 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 11, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 5 1920, to May 11 1920,that I saw her alive on May 10 1920,and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) + yrs. + mos. 8 ds.CONTRIBUTORY
(Secondary)(Duration) yrs. mos. ds.(Signed) Charles E. Clark M. D.May 11, 1920 (Address) 1306 N. Gilmer

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Charles E. Clark May 14 1920

20-UNDERTAKER

ADDRESS

Edw. Ringgold 1463 Carey

important. See instructions on back of certificate.

D43095

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43095

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 Madison Ave ST. 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Carter(Residence in Baltimore: No. 904 Madison Ave St. 11 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Widowed

6-DATE OF BIRTH,

May

(Month)

11

(Day)

1847

(Year)

7-AGE,

72

yrs.

mos.

da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired Farmer
0869-BIRTHPLACE,
(State or Country),Appomattox Va

PARENTS.

10-NAME OF FATHER,

T. Carter11-BIRTHPLACE OF FATHER
(State or Country),Appomattox

12-MAIDEN NAME OF MOTHER

Julia Morgan13-BIRTHPLACE OF MOTHER
(State or Country),Appomattox

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. E. Childress(Address) 904 Madison Ave

15-

MAY 12 1920

Robert P. Harrison,

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

(Month)

11

(Day)

1920

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 9th 1920, to May 11th 1920,that I saw him alive on May 11 1920,and that death occurred, on the date stated above, at 11:20 m.

The CAUSE OF DEATH* was as follows:

Cancer of liver (hepatoma)not known (Duration).....yrs.....mos.....da.CONTRIBUTORY (Secondary) Exhaustion

(Duration).....yrs.....mos.....da.

(Signed) Robert P. Harrison M. D.May 12, 1920 (Address) 937 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

Spring Street Va

DATE OF BURIAL,

5-12-20, 1920

20-UNDERTAKER

Samuel R

ADDRESS

5111W. B. Cunningham Schmidt St

Bam Bain

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43096

CERTIFICATE OF DEATH.

D43096

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3543 Liberty Heights Ave* ST. *13* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Anna Christina Hughes*

(Residence in Baltimore: No. *3543 Liberty Heights Ave* St. *47* yrs. *9* mos. *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *F*

4-COLOR OR RACE *W*

5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH, *July 14, 1872*

7-AGE, *47* yrs. *9* mos. *5* ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... *None*
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country) *Baltimore Md*

10-NAME OF FATHER, *George Pahl*

11-BIRTHPLACE OF FATHER (State or Country) *Germany*

12-MAIDEN NAME OF MOTHER *Catherine Snyder*

13-BIRTHPLACE OF MOTHER (State or Country) *Baltimore Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William J. Hughes*

(Address) *3543 Liberty Heights Ave*

15-

Robert P. Harrison,

Filed *May 12 1920*

191

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *May 10th, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 1st 1920*, to *May 10th 1920*, that I saw her alive on *May 10th 1920*, and that death occurred, on the date stated above, at *7* p. m.

The CAUSE OF DEATH* was as follows:

Cardiomyopathy of Pericardium & Liver

(Duration) *1* yrs. *1* mos. *1* ds.

CONTRIBUTORY (Secondary) *Pulmonary Embolism*

(Signed) *W. J. Hughes* M. D.
W. J. Hughes (Address) *6 E. Mead St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Woodlawn Cemetery*

DATE OF BURIAL, *May 13, 1920*

20-UNDERTAKER *George Smith*

ADDRESS *1000 G St*

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D4309Z

D43097

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 247 N. Green ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: 63 yrs., mos. ✓ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

8-SEX.

4-COLOR OR RACE.

5-SINGLE *Widow*
 MARRIED
 WIDOWED
 OR DIVORCED,
 (Write the word.)

C-DATE OF BIRTH.

7-AGE.

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE
OF FATHER
(State or Country).

12-MAIDEN NAME
OF MOTHER

**13-BIRTHPLACE
OF MOTHER
(State or Country).**

14-THU ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address

Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH.

17. I HEREBY CERTIFY, That I attended deceased from May 1 19120, to May 10 19129,
that I saw her alive on May 10 19120,
and that death occurred, on the date stated above, at 1145 m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(SIGNED)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death	hrs.	mos.	da.	In the State	hrs.	mos.	da.
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Where was disease contracted,
if not at place of death?

Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS 114 Ave

MAY 12 1920

D43098

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43098

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *16* ST.: *16* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *1405 Poplar Grove* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Eunice Booker*

6 DATE OF BIRTH (month, day, and year)

Sept. 12, 1848

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*71**7**29*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

050

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Balto Md*

10 NAME OF FATHER

John L. Booker

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Eunice Knight

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant

(Address)

Edw. Booker
1405 Poplar Grove St

15

Filed

19

MAY 12 1920

Robert F. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 11 - 1920*

17

I HEREBY CERTIFY, That I attended deceased from

April 5, 19 *20*, to *May 11*, 19 *20*,that I last saw him alive on *May 11*, 19 *20*,and that death occurred, on the date stated above, at *10 30 P. m.*

The CAUSE OF DEATH* was as follows:

Pneumonia - Broncho(duration) yrs. mos. *5* ds.CONTRIBUTORY
(Secondary)*Hypertrophic Prostate*(duration) *2* yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *yes* Date of *May 5 - 1920*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

E. S. Foster

M. D.

5/12, 1920 (Address) *Md. General Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Lowdon Park Cem.**May 14 1920*

20 UNDERTAKER

ADDRESS *1944**Narry W. Ehlert W. North*

D43099

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43099

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Josephs Hosp.* ST.: *10* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Math Edward(a) RESIDENCE. NO. *316 E Biddle St* ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Married*6 DATE OF BIRTH (month, day, and year) *1891*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

alt. 29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Elizabeth N. J.

10 NAME OF FATHER

Don't know.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

*Robert Edwards**316 E Biddle St*

MAY 12 1920

Filed

19

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 11* 19 *20*17 I HEREBY CERTIFY, That I attended deceased from *May 6*, 19*20*, to *May 11*, 19*20*, that I last saw her alive on *May 11*, 19*20*, and that death occurred, on the date stated above, at *10 P* m. The CAUSE OF DEATH* was as follows:*General Peritonitis*CONTRIBUTORY (Secondary) *Surgeon General* (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *yes* Date of *May 6 - 20*Was there an autopsy? *yes*What test confirmed diagnosis? *Examination*

(Signed)

J. T. Darr

M. D.

19

(Address) *St Josephs Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Elizabeth - Essex Co. N. J.

DATE OF BURIAL

19

20 UNDERTAKER

William Cook

ADDRESS

522 S. North Ave

TION is very important. See instructions on back of certificates.

D43100

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

White Ave near Belair Rd. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Fannie A. Baker

(a) RESIDENCE. NO.

White Ave near Belair Rd. ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 8 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Alfred Baker

6 DATE OF BIRTH (month, day, and year)

Sept 11-1852

7 AGE

Years

Months

Days

If LESS than 1 day. — hrs. or — min.

68

8

—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(h) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

John Gray

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Lydia Talbot

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

Alfred Baker White Ave near Belair Rd.

Robert F. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Apr 5 1920, to May 11 1920, that I last saw her alive on May 11 1920, and that death occurred, on the date stated above, at 6:10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

Chronic Bronchitis (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B Green, M. D.

5/12 1920 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Putty Hill Cemetery

May 14 1920

20 UNDERTAKER

George H. Halland

1831 KMD

TION is very important. See instructions on back of certificates.

MAY 12 1920

Burial Permit Clerk

D43101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D43101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 S. Bethel St. ST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Frisby

(a) RESIDENCE. No.

320 S. Bethel St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Widowed

6 DATE OF BIRTH (month, day, and year)

1859

7 AGE

61

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

Washing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

A. C. Co

10 NAME OF FATHER

Henry Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country)

A. C. Co

12 MAIDEN NAME OF MOTHER

Mary Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

A. C. Co

14

Informant (Address)

Ella Robertson 320 S. Bethel St.

15

MAY 13 1920

ROBERT I. FLAHERTY Registrar

Burial Permit 0147

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 1, 1920, to May 11, 1920,

that I last saw her alive on May 11, 1920,

and that death occurred, on the date stated above, at 1.10 P. M.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs
Tuberculosis of Lungs
Lungs

(duration) yrs. 5 mos. 4 ds.

CONTRIBUTORY (Secondary)

Haemorrhage of Lungs (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. G. W. Kennard, M. D.

5-12 1920 Address 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Moythly Lane

May 14 1920

20 UNDERTAKER

John W. Henderson

ADDRESS 1502

E. H. Movement

TION is very important. See instructions on back of certificates.

D43102

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43102

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. *1224 Asquith* ST. *10* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Washington B. Wilcox(a) RESIDENCE. NO. *1224 Asquith* ST. WARD.(Usual place of abode) *also*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *60* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Not Known*7 AGE *60* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balt.* (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) *Balt.* (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) *Balt. Md.* (State or country)

14

Informant (Address)

15

MAY 13 1920

ROBERT E. KLEATTE

Baptist Church

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 11* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from *May 6*, 19*20*, to *May 11*, 19*20*, that I last saw him alive on *May 11*, 19*20*, and that death occurred, on the date stated above, at *8:45 P.* m. The CAUSE OF DEATH* was as follows:*Cerebral Hemorrhage*(duration) yrs. mos. *5* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Autopsy*(Signed) *Hubert A. Knapp, M. D.**1716 E. Preston St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Green Park Cemetery

DATE OF BURIAL

May 14 19*20*

20 UNDERTAKER

Henry Hood & Son

ADDRESS

1301 E. Eager St.

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43103

CERTIFICATE OF DEATH.

50 D43103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hosp.*)ST.: *9* WARD)

2-FULL NAME

John W. Gallagher

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

532 E. 20th St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *58* yrs. *2* mos. *18* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mr. Helen Gallagher

6 DATE OF BIRTH (month, day, and year)

Feb. 28, 1862

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*58**2**18*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Attorney

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

Arthur Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md.

12 MAIDEN NAME OF MOTHER

Bridget Cotton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md.

14

Informant (Address)

Mary Hospital Record

15

MAY 13 1920

ROBERT E. KRAUTER
Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*5/12*19*20*

17

I HEREBY CERTIFY, That I attended deceased from

4/17, 19*20*, to *5/12*, 19*20*, that I last saw him alive on *5/12*, 19*20*, and that death occurred, on the date stated above, at *2.45* p.m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus(duration) *3* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Wm. D. R. R. R.* M. D.(Address) *Mary Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Cross Cemetery**May 14 1920*

20 UNDERTAKER

ADDRESS

*Henry W. Means & Son**805 N. Calvert*

TION is very important. See instructions on back of certificates.

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43104

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43104

CERTIFICATE OF DEATH.

Adlington

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

Kenneth Ave., Extension

ST.

WARD)

2-FULL NAME

Martin Radtka

(Residence in Baltimore: No.

3123 Elliott St.

St.; yrs.

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married* (Write the word.)

6-DATE OF BIRTH, *Sept. 5, 1855* (Month) (Day) (Year)

7-AGE, *64 yrs. 8 mos. 5 ds.* If LESS than 1 day, ... hrs. or ... mo.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *retired Baltimore* (b) General nature of industry, business, or establishment in which employed (or employer), *OHV*

9-BIRTHPLACE, (State or Country), *Poland*

PARENTS. 10-NAME OF FATHER, *Michael Radtka* 11-BIRTHPLACE OF FATHER (State or Country), *Poland* 12-MAIDEN NAME OF MOTHER, *Not known* 13-BIRTHPLACE OF MOTHER (State or Country), *Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant), *Amelia Radtka* (Address), *3123 Elliott St.*

15- MAY 13 1920 ROBERT F. KRAUTER Filed

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 10, 1920* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows:

Struck by railroad train
Accident
Instant death (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) *J. D. Henderson* M. D. (Coroner) *May 11, 1920* (Address) *2302 E. Enoch Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death, yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Schwartz's Cemetery* DATE OF BURIAL, *May 13, 1920* 20-UNDERTAKER, *Girkler + Girkler* ADDRESS, *1739 E. Eager*

D43105

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105 D43105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1739 E. Eager ST.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie M. Poole(a) RESIDENCE. NO. 1739 Eager ST.; 7 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fr. 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed or divorced HUSBAND of (or) WIFE of Wm B. Poole6 DATE OF BIRTH (month, day, and year) July 28, 18937 AGE Years 26 Months 9 Days 14 If LESS than 1 day, hrs. or min.8 OCCUPATION OF DECEASED Housekeeper
(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)10 NAME OF FATHER Geo. F. Spahn11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)12 MAIDEN NAME OF MOTHER Mary La Roche13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)14 Informant Mary E. Spahn
(Address) 26 E. Eager Ave15 MAY 13 1920 ROBERT B. TRAUTER
Burial Permit OTHER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12th 192017 I HEREBY CERTIFY, That I attended deceased from May 5th, 1920, to May 11th, 1920
that I last saw her alive on May 11th, 1920
and that death occurred, on the date stated above, at 5:00 m.

The CAUSE OF DEATH* was as follows:

Gastro Intestinal Catarrh(duration) yrs. mos. 14 ds.CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) J. A. Palmer, M. D., 19 (Address) 1501 E. Eager Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL May 15 192020 UNDERTAKER Jurkles & Jurkles ADDRESS 1739 Eager

TION is very important. See instructions on back of certificates.

D43106

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D43106

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 Roland Ave ST.; 27 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 324 Roland Ave St.; life yrs., 4 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED, married

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

Dec. 23, 1848
(Month) (Day) (Year)

7-AGE,

71 yrs. 4 mos. 19 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE,
(State or Country),Balto. Md

10-NAME OF FATHER,

Wm E. Hooper11-BIRTHPLACE OF FATHER
(State or Country),Balto.

12-MAIDEN NAME OF MOTHER

Catharine Bell13-BIRTHPLACE OF MOTHER
(State or Country),Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert James Smith(Address) 324 Roland Ave

15-

MAY 13 1920

ROBERT A. KLAUTER

Filed

191

Baltimore City Health Department

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 11, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 12 1919, to May 11 1920,that I saw her alive on May 11 1920,and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Aortic & Mitral insufficiency.

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Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43107

CERTIFICATE OF DEATH.

151 D43107

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Cook

(a) RESIDENCE. No.

1128 Druid Hill Ave. ST. 7 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, 8 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

MAY 13 1920ROBERT A. HARRISSerial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 11 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 10 1920, to May 11 1920,that I last saw him alive on May 11 1920,and that death occurred, on the date stated above, at 4:00 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Oliver W. Harris, M. D.(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Commissioner Health,

ADDRESS

MAY 12 1920

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43108

CERTIFICATE OF DEATH.

28 D43108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 W. Saratoga ST.; 4 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E. Langston(Residence in Baltimore: No. 720 W. Saratoga St.; 43 yrs., 2 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)

6-DATE OF BIRTH, Feb. 28, 1877 (Month) (Day) (Year)

7-AGE, 43 yrs., 2 mos., 12 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housework
(b) General nature of industry, business, or establishment in which employed (or employer), at home

9-BIRTHPLACE, (State or Country), Baltimore Md10-NAME OF FATHER, Henry Jackson11-BIRTHPLACE OF FATHER (State or Country), Maryland12-MAIDEN NAME OF MOTHER, Louise Gross13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie E. Langston(Address) 720 W. Saratoga St.

15-

MAY 13 1920

191.

ROBERT B. KRAUTER

Bacial Permit Officer

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 10th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 14 1920, to May 10 1920, that I saw her alive on May 9 1920, and that death occurred, on the date stated above, at 11:30 m. The CAUSE OF DEATH* was as follows:

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

CONTRIBUTORY (Secondary) Pneumonia (Duration) 6 yrs., 6 mos., 11 ds.(Signed) Edward E. Jackson, M. D. (Address) 1239 W. North St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, 43 yrs., 2 mos., 12 ds. In the State 43 yrs., 2 mos., 12 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Westview DATE OF BURIAL, May 13, 192020-UNDERTAKER, Sam'l W. Colwell ADDRESS, 1400 N. Chesapeake

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43109

CERTIFICATE OF DEATH.

151 D43109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* ST.; *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Baby Magofski*(a) RESIDENCE. No. *2501 E Pratt St.* ST. *1* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *5/12-20*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

M-10 Mos

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Mary Hospital Baltimore Md*10 NAME OF FATHER *Stanislaus Magofski*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Poland*12 MAIDEN NAME OF MOTHER *Annica Miskul*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Poland*

14

Informant (Address) *Stanislaus Magofski 2201 E Pratt St*

15

*MAY 13 1920**ROBERT E KRAUTER*

Registrar

Serial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 12 1920*

17

I HEREBY CERTIFY, That I attended deceased from

May 12 1920, to *May 12 1920*.that I last saw him alive on *May 12 1920*.and that death occurred, on the date stated above, at *1:25* a.m.

The CAUSE OF DEATH was as follows:

*Summum Buth**(6 Months)*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *A. Samuels* M. D., 19 (Address) *1928 Eutan Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Rosary**5/18 1920*

20 UNDERTAKER

ADDRESS

*Wm. Falkowski**168 East*

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43110

CERTIFICATE OF DEATH.

43 D43110

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St. Agnes Hospital, ST. 8

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Miss Ella K. Underwood

(a) RESIDENCE. No.

2209 Harford Road ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

64 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

May 21-1855

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

or min.

64

11

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Not anything

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Joshua Underwood

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maine

12 MAIDEN NAME OF MOTHER

Margaret Button

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant

(Address)

Alice G. Wilkinson
2209 Harford Road

15

MAY 13 1920

ROBERT E. KRAUTER

Registrar

Burial Permit 6101

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 11 - 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 21

1920, to

May 11

1920

that I last saw her alive on

May 11

1920

and that death occurred, on the date stated above, at

8 P. M.

The CAUSE OF DEATH* was as follows:

Breast Carcinoma

(duration)

2 yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

Yes

Date of

1919

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. Lawrence M. D.

, 19 (Address)

St. Agnes' Hosp.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park Cem.

May 14

1920

20 UNDERTAKER

ADDRESS

Wm. E. Black

927 N. Broadway

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D43111

CERTIFICATE OF DEATH.

REGISTERED NO.

D43111

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1708 Aliceanna* ST.; *92* WARD) ✓

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Rosario Senio(a) RESIDENCE. NO. *1708 Aliceanna* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*.5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Anthony Senio*6 DATE OF BIRTH (month, day, and year) *Feb 14 - 1887*7 AGE Years *33* Months *2* Days *28* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*(b) General nature of industry, business, or establishment in which employed (or employer) *at home*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Italy*10 NAME OF FATHER *Aspero Scandina*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Italy*12 MAIDEN NAME OF MOTHER *Concetta Naso*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Italy*14 Informant *Anthony Senio* (Address) *1708 Aliceanna St.*

MAY 13 1920

ROBERT E. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 12 1920*17 I HEREBY CERTIFY, That I attended deceased from *May 3 -*, 19*20*, to *May 12 -*, 19*20*,that I last saw her alive on *May 11 -*, 19*20*,and that death occurred, on the date stated above, at *4:30 P. M.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(duration) yrs. mos. *8* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Eugene L. Perrugno*, M. D.*May 1920* (Address) *2314 E. Balt St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Ch.**May 14 1920*

20 UNDERTAKER

ADDRESS

*Lilly and Zeller**4034 Mt. St.*

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43112

CERTIFICATE OF DEATH.

64 D43112

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1912 Cedar Rd* *Waller St.* WARD)2-FULL NAME *OTIS Jackson Tall Sr*(a) RESIDENCE. NO. *1912 Cedar Rd* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *53* yrs. *11* mos. *22* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Onia Broughton Tall*6 DATE OF BIRTH (month, day, and year) *May 14 1866*7 AGE Years *53* Months *11* Days *22* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Owner*(b) General nature of industry, business, or establishment in which employed (or employer) *Printing Establishment*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md* (State or country)10 NAME OF FATHER *George H. Tall*11 BIRTHPLACE OF FATHER (city or town) *Cambridge Md* (State or country)12 MAIDEN NAME OF MOTHER *Amanda B. Jones*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore Md* (State or country)

14

Informant (Address) *Abraham Tall 1912 Cedar Rd*

15

MAY 13 1920

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 11 1920*17 I HEREBY CERTIFY, That I attended deceased from *September 25 1919* to *May 11 1920*that I last saw him alive on *May 10 1920*and that death occurred, on the date stated above, at *5 a* m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Control Hypertension(duration) yrs. *9* mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. — mos. *3* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *above*(Signed) *W. H. Shirley Perkins* M. D., 19 (Address) *W. H. Shirley Perkins*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

LOUION PARK

MAY 13 1920

20 UNDERTAKER

ADDRESS

JOHN F. DENNY

715 LIGHT ST.

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43113

CERTIFICATE OF DEATH.

170 D43113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 S. Spring St. ST.; 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 309 S. Spring St. St.; 10 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, Colored 5-SINGLE, Married
 MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, May 4, 1869
 (Month) (Day) (Year)

7-AGE, 57 yrs., 4 mos., 6 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work, Laborer on buildings
 (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Jacksonville, Fla.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), not known

12-MAIDEN NAME OF MOTHER, not known

13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Angela Brown

(Address) 309 S. Spring St.

15- MAY 13 1920

Filed..... 191..... ROBERT E. KAUTER

Barial Permit 0187

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 10, 1920
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 3, 1920, to May 10, 1920, that I saw him alive on May 10, 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(Duration)..... yrs. 3 mos. 0 ds.
 CONTRIBUTORY Chronic Bronchitis
 (Secondary) Rephritis (Duration)..... yrs. 6 mos. 0 ds.
 (Signed) Richard J. Goshen M. D.
May 10, 1920 (Address) 1514 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Harv St. Grace M. May 13, 1920

20-UNDERTAKER ADDRESS Mrs. Robert A. White

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43114

CERTIFICATE OF DEATH.

92

D43114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 134 Richmond ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 134 Richmond St.; 40 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored5-SINGLE,
MARRIED, married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

unknown, 1888
(Month) (Day) (Year)

7-AGE,

52 yrs. 0 mos. 0 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....Caterer
Catering9-BIRTHPLACE,
(State or Country).Virginia10-NAME OF
FATHER,Daniel Young11-BIRTHPLACE
OF FATHER
(State or Country),Virginia12-MAIDEN NAME
OF MOTHERCatherine Young13-BIRTHPLACE
OF MOTHER
(State or Country),Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca Young(Address) 134 Richmond St.

15-

MAY 13 1920ROBERT E. KRAUTER

Filed.....

191.....

BUTLER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May, 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Feb 12th 1920, to May 10th 1920,that I saw him alive on May 10th 1920,and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows: ..

Pulver Pneumonia(Duration).....yrs. 9 mos.ds.CONTRIBUTORY
(Secondary)Arterio Sclerosis(Duration).....yrs. 10 mos.ds.(Signed) R. E. Krauter M. D.May 11th 1920 (Address) 2442 Dolphin St.*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.mos.ds. In the State.....yrs.mos.ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

McAuburn cemeteryMay 15 1920

20-UNDERTAKER

ADDRESS 1725Mrs Robert A. Elliott

D43115 30

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43115 82

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Berry Turner

(a) RESIDENCE. NO.

Fairfield Rd. ST. 17 WARD. 17

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

+

6 DATE OF BIRTH (month, day, and year)

unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Stafford Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Janet Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

2441 Friends

15

MAY 13 1920

ROBERT F. L. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 19, 1920, to May 7, 1920,that I last saw her alive on May 7, 1920,and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Anterior extension of
hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. H. Bennett M. D., 19 (Address) 1720

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Auburn cemeteryMay 13 1920

20 UNDERTAKER

ADDRESS

Mrs. Rolt a. Elliott1720

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

MORE ✓ D43116

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 811 Brunswick ST., WARD

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 9* 19*70*

17 I HEREBY CERTIFY, That I attended deceased from
March 10, 1920, to May 9, 1920.

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14 18

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
18	18	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER *Fred Schmidt*

11 BIRTHPLACE OF FATHER (city or town)
(State or country) *Germany*

12 MAIDEN NAME OF MOTHER *D. A. Kane*

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) *London*

14 Informant John Weigman
(Address) 1111 1st St. N.E.

15 MKV 1 5 1050 BOSTON E. PRATER.

BUFFET FOUNTAIN

2nd that death occurred, on the date stated above, at... 7:20 p.m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) 2 hrs. 5 ds.

CONTRIBUTORY (Secondary) *Helmut von Helldorf*

(duration) yrs. mos. 74 ds.

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death? no Date of 11/1/68

Was there an autopsy?.....

What test confirmed diagnosis?

(Signed) David M. Smith, M. D.

7/13, 1944 (Address) 547 7th St. N. W.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL

Baltimore, Maryland May 14th 1860

20 UNDERTAKER Jos Joesdens Son ADDRESS 217 S. B...

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43117

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1053 W. Fayette ST.; 18 WARD)2-FULL NAME Charles Rothel(Residence in Baltimore: No. 1053 W. Fayette St.; 76 yrs., 7 mos. 12 ds.)REGISTERED NO. C 043117

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, married
(Write the word.)6-DATE OF BIRTH Sept 29, 1843
(Month) (Day) (Year)7-AGE, 76 yrs., 7 mos., 12 ds. IF LESS than 1 day,hrs. ormin.8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Market man
(b) General nature of industry, business, or establishment in which employed (or employer) 0869-BIRTHPLACE, (State or Country), Baltimore City10-NAME OF FATHER, Unknown11-BIRTHPLACE OF FATHER (State or Country), Unknown12-MAIDEN NAME OF MOTHER Unknown13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isabel Rothel(Address) 1053 W. Fayette St.15 MAY 13 1920 ROBERT B. KRAUTERFiled..... 191... 1053 W. Fayette St. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 11, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from March 17, 1920, to May 11, 1920, that I saw h. in alive on May 10, 1920, and that death occurred, on the date stated above, at 1034 n.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema..... (Duration)..... yrs. 3 mos. ds.CONTRIBUTORY mitral stenosis
(Secondary)

..... (Duration)..... yrs. mos. ds.

(Signed) John A. Evans, M. D......, 191... (Address) 101 St. Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Int. Clint DATE OF BURIAL, May 13, 192020-UNDERTAKER Harry H. Witzke ADDRESS 1531 W. Lombard

D43118

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 40 D43118

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Balto. Gen. Hospital 90* ST. *90* WARD)

REGISTERED NO. C.....

2-FULL NAME

Minnie T. Hanagan

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1848 W. Balto.* St.; yrs., mos. *14* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH,

October 12, 1854
(Month) (Day) (Year)

7-AGE,

65 yrs. *0* mos. *30* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Seamstress*(b) General nature of industry, business, or establishment in which employed (or employer) *69*9-BIRTHPLACE, (State or Country), *Norfolk, Va.*10-NAME OF FATHER, *John M. Wells*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Wilhelmina*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Bertha T. Stewart*(Address) *1848 W. Balto. St.*

15-

MAY 13 1920

ROBERT B. KAUFER

Registrar
Baltimore Health Department

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 5, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 5, 1920, to May 11, 1920,*that I saw her alive on *May 11, 1920,*and that death occurred, on the date stated above, at *10:30 P. m.*

The CAUSE OF DEATH* was as follows:

Carcinomatosis(Duration) *?* yrs. *?* mos. *?* ds.CONTRIBUTORY *St. bid. Cardiac failure*

(Secondary)

(Duration) *?* yrs. *?* mos. *?* ds.(Signed) *Wilhelmina Fort* M. D.*May 12, 1920* (Address) *1313 Eighth St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *6* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Philadelphia Pa.*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*New Cathedral**May 14, 1920*

20-UNDERTAKER

ADDRESS

*Harry H. Witzke**1531 W. Lombard*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43119

CERTIFICATE OF DEATH.

X 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Johns Hopkins Hospital

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lorena D. Smith

(a) RESIDENCE. No.

1131 E. Pratt St

ST.

WARD.

Hawville Ill.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 2, 1844

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

76

1

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

New York

10 NAME OF FATHER

Henry C. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

New York

12 MAIDEN NAME OF MOTHER

Harriet Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

New York

14

Informant (Address)

Hospital Records

15

Filed

19

MAY 13 1920

ROBERT E. TRAUTER

Social Examin

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 3, 1920, to May 9, 1920,

that I last saw him alive on May 9, 1920,

and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Injury caused by fall

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) O. B. Bloomfield M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Barnie Brae Can

5/14 1920

20 UNDERTAKER

ADDRESS

Jack Lewis

1411 E. Pratt St

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43120

CERTIFICATE OF DEATH.

D43120

1-PLACE OF DEATH

Biedler & Sellman Sanatorium
CITY OF BALTIMORE: (No. 2724 North Charles St. ST. 12 WARD)

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

2-FULL NAME Elizabeth McCall McKindsey

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD

Toronto Canada

(If nonresident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 6 mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed,
or Divorced (write the word) Widow5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thomas McKindsey

6 DATE OF BIRTH (month, day, and year) Oct, 6, 1840

7 AGE Years 79 Months 7 Days 6 If LESS than
1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work None(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Toronto, Canada
(State or country)

10 NAME OF FATHER ----- Barker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Canada

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Canada

14

Informant Mrs. Louise Crespi
(Address) Waco, Texas

MAY 13 1920

ROBERT A. TRAUBER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1920

17 I HEREBY CERTIFY, That I attended deceased from
April 1, 1920, to May 12, 1920,
that I last saw him alive on May 12, 1920,
and that death occurred, on the date stated above, at 8:50 P. M.
The CAUSE OF DEATH* was as follows:Myocarditis
(duration) yrs. 4 mos. ds.CONTRIBUTORY Secondary
(duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death? 723 H. Calver St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edmond P. Smith, M. D.

5/13, 1920 (Address) 237 H. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Greenmount Cemetery

DATE OF BURIAL

May 13 1920

20 UNDERTAKER

Henry W. Mears & Son

ADDRESS

805 N. Calv

ERT

TION is very important. See instructions on back of certificates.

D43122

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 St PaulST.: 11

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Wiley Mc Clendon(a) RESIDENCE. NO. 723 St. Paul

(Usual place of abode)

ST.: 11WARD. Dadeville Ala

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 ~~Single, Married, Widowed,~~
or ~~Divorced~~ (write the word)malewhitemarried5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofJessie Mc Clendon6 DATE OF BIRTH (month, day, and year) 1863-3-24

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.67219

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workPhysician(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Tallapoosa Co
Ala.10 NAME OF FATHER Joseph Mc Clendon11 BIRTHPLACE OF FATHER (city or town)
(State or country)Alabama12 MAIDEN NAME OF MOTHER Mary Bernon13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Alabama

14

Informant
(Address)Mrs Jessie Mc Clendon
Dadeville Ala.

15

MAY 13 1920ROBERT B. J. JETER

Registrar

Serial Permit 1101

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 6, 1920, to May 13, 1920,that I last saw him alive on May 12, 1920,and that death occurred, on the date stated above, at 1 9 m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Physical Exam.

(Signed)

Wallace A. Barker, M. D.

, 19

(Address)

400 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Dadeville Alabama

DATE OF BURIAL

5-13 1920

20 UNDERTAKER

Henry W. Jackson & Sons Co

ADDRESS

McClendon
Orchard

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43123

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2109 Chelsea Terrace ST. 13 WARD)2-FULL NAME William H. Watson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2109 Chelsea Terrace, 44 yrs., 9 mos., 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>male</u>	4-COLOR OR RACE. <u>white</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <u>Married</u> (Write the word.)
6-DATE OF BIRTH, <u>Oct</u> <u>16</u> , 18 <u>74</u> (Month) (Day) (Year)		
7-AGE, <u>45</u> yrs., <u>6</u> mos., <u>26</u> ds. If LESS than 1 day, hrs. or min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <u>Printer</u> (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE, (State or Country), <u>Washington D.C.</u>		
PARENTS.	10-NAME OF FATHER, <u>William H. Watson</u>	
	11-BIRTHPLACE OF FATHER (State or Country), <u>Md.</u>	
	12-MAIDEN NAME OF MOTHER, <u>Louise Callison</u>	
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Md.</u>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Watson(Address) 2109 Chelsea

15-MAY 13 1920

ROBERT B. KEAUTER

Filed....., 191.....

BURIAL PERMIT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 12, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Nov 1 1919, to May 12 1920,
that I saw him alive on May 11 1920,
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration)..... yrs..... mos..... ds.
CONTRIBUTORY.....
(Secondary) Tuberculosis pulmonary

(Duration)..... yrs..... mos..... ds.
(Signed) W. S. Rublett M. D.
May 12, 1920 (Address) 3402 E. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Lorraine Cemetery

DATE OF BURIAL,

May 15th, 1920

20-UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E. Monument St.

D43124

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43124

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hosp.*)ST.: *4*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. *N. Tomlinson*(a) RESIDENCE. NO. *Hawthorn, name*ST.: *4*

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb. 4 1900*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*26**3**5*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

Steamship

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Jafar Tomlinson*10 NAME OF FATHER *Koorn*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Jafar*12 MAIDEN NAME OF MOTHER *Maha*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Jafar

14

Informant (Address)

Robert P. Harrison,

OVER

+ 170

4

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/7 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*5/7**1920**5/4**1920*

that I last saw him alive on

*5/4**1920*

and that death occurred, on the date stated above, at

2.20 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Dilatated
myocard

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Kraemia

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Wm. D. Pugh

M. D.

5/7, 1920 (Address)

Mary Hosp.

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mary Hospital

20 UNDER

Wm. D. PUGH

DRES

TION is very important. See instructions on back of certificates.

MAY 13 1920

Burial Permit Clerk

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Baltimore, Md., May 27 1920.

I do hereby make oath that the name, N. Torminowe,
given on Health Department Certificate of Death,
No. D. - 43124, is incorrect and that the same
should be Naomasa Tomiyama.

Lucie D. Ridgeley
Physician

Subscribed and sworn to before me this 27th day of May, 1920.

Reed Gaither
Notary Public.

ATTESTMENTS

art disease;
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lia" (merely
coma," "Con-
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e," "Hemor-
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HEALTH DEPARTMENT—CITY OF BALTIMORE

D43125

D43125

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2710 W. North Ave. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Clinton Schaffer, Jr.Residence in Baltimore: No. 2710 W. North Ave. ST. 15 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male4-COLOR OR RACE, White5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word)6-DATE OF BIRTH, May 10, 1918

(Month)

(Day)

(Year)

7-AGE, 2 yrs. ✓ mos. 2 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Baltimore, Md.10-NAME OF FATHER, Howard Clinton Schaffer11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.12-MAIDEN NAME OF MOTHER Katherine Isabel Emerick13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. K. Emerick(Address) 2710 W. North Ave.

15-

Robert P. Harrison

MAY 13 1920

191

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 12, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from May 11, 1920, to May 12, 1920, that I saw him alive on May 11, 1920, and that death occurred, on the date stated above, at 11 a. m. The CAUSE OF DEATH* was as follows:Pneumonia
(Duration).....yrs.....mos.....ds.CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Howard C. Todd M. D.May 12, 1920 (Address) 735 N. Fulton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Corraeul CemDATE OF BURIAL, May 14, 192020-UNDERTAKER, W. A. FischerADDRESS 2710 W. North Ave.

D43126

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43126

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mrs. Koch*)ST.: *22* WARD)REGISTERED NO. *28-092*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Edward H. Koch*(a) RESIDENCE. No. *22 W. Church*

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Negro

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 5, 1898

7 AGE

22

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Kentucky

10 NAME OF FATHER

Charles H. Koch

11 BIRTHPLACE OF FATHER (city or town) (State or country)

15

12 MAIDEN NAME OF MOTHER

Carrie H. Koch

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

15

14

Informant (Address)

Robert P. Harrison

15

Filed *May 13 1920*

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*5/6*19 *U*

17

I HEREBY CERTIFY, That I attended deceased from

5/5, 19 *20*, to *5/6*, 19 *20*that I last saw him alive on *5/6*, 19 *20*and that death occurred, on the date stated above, at *11:30 a.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Wm. D. Ridge*, M. D.*5/6*, 19 *20* (Address) *Mrs. Koch*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND

20 UNDERTAKER

ADDRESS

Commissioner Health,

MAY 13 1920

TION is very important. See instructions on back of certificates.

D43127

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43127

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 Rosedale Terrace ST. 10 WARD)

2-FULL NAME

Elijah Mpton Price

(a) RESIDENCE. NO. 405 Rosedale Terrace ST. 10 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

white

5 Single, Married, Widowed,
or Divorced (write the word)

married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Mrs Price

6 DATE OF BIRTH (month, day, and year)

August 9, 1860

7 AGE

59

Years

9

Months

3

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Molorman H.R.C.C.

(b) General nature of industry,
business, or establishment in
which employed (or employer)

078

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore County

10 NAME OF FATHER

Elijah M. Price

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Baltimore Co

12 MAIDEN NAME OF MOTHER

Lucy E. Mott

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Baltimore

14

Informant

(Address)

Mrs Price

405 Rosedale Terrace

15

Full Name

Robert P. Harrison,

Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 20

May 12 1920

17 I HEREBY CERTIFY, That I attended deceased from

May 11, 1920, to May 12, 1920.

that I last saw him alive on May 12, 1920.

and that death occurred, on the date stated above, at 1:40 P.M.

The CAUSE OF DEATH* was as follows:

Coronary Arteriosclerosis

(duration) yrs. mos. ds. 7

CONTRIBUTORY
(Secondary)

Cardiac Arteriosclerosis

(duration) yrs. mos. ds. 2 hrs.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. Theo. Kaldewey, M. D.

May 13 1920 (Address) 34 So Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cem

May 16 1920

20 UNDERTAKER

ADDRESS

Henry Lutz 1007 N. Bond St.

TION is very important. See instructions on back of certificates.

AY 13 1920

D43128

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43128

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Church Home & Infirmary* ST. *6* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *30* yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *Nov-23-1836*7 AGE Years *83* Months *5* Days *20* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Lancaster, Md.* (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) *76* (State or country) *Vermont*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) *Maryland* (State or country)

14

Informant *George Ritz* (Address) *H 3 P. Leavelle St.*

15

MAY 13 1920

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 13* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from *Feb. 15* 19 *20*, to *May 13* 19 *20*, that I last saw him alive on *May 13* 19 *20*, and that death occurred, on the date stated above, at *2:40 A.* m. The CAUSE OF DEATH* was as follows:*Carcinoma of the Rectum
General Carcinomatosis*

(duration) yrs. mos. ds.

CONTRIBUTORY

Acute Intestinal Obstruction (duration) yrs. mos. ds. *8*18 Where was disease contracted if not at place of death? *Church Home & Inf.*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *autopsy* (Signed) *Zach. A. Morgan* M. D.19 (Address) *Church Home & Inf.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Landon Park Cemetery**May 14 1920*

20 UNDERTAKER

ADDRESS

*H. E. Hughes**17 S. Broadway*

TION is very important. See instructions on back of certificates.

D43129

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAY 13 1920 Robert P. Harrison,

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1920, to May 12 1920, that I saw him alive on May 11 1920, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

CONTRIBUTORY (Secondary) Exhaustion

(Signed) Luigi D. Di Stefano M. D.
May 12, 1920 (Address) 407 N. Exeter St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

D43130

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ D43130

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1161 Garesnuck Ave. ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1161 Garesnuck Ave. St.; 9 yrs., 12 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE,

marriedwidowedor divorced

(Write the word.)

6-DATE OF BIRTH.

May 1, 1920
(Month) (Day) (Year)

7-AGE,

12 yrs., 12 mos., 12 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert P. Harrison(Address) 2831 Carroll St.

15-

Robert P. Harrison,
191
May 13 1920
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 13, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 1, 1920 to May 13, 1920, that I saw him alive on May 12, 1920 and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial sclerosis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) W. H. Harrison M. D......, 101... (Address) 2831 Carroll St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer Cemetery May 14, 1920

20-UNDERTAKER

ADDRESS

George J. Ruth 1735 Hayford
Ave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

D43131

(Alvire Broughlin)
HEALTH DEPARTMENT—CITY OF BALTIMORE

D43131

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2620 Frederick Ave ST. 20 WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Alvire Broughlin

(Residence in Baltimore: No. 2620 Frederick Ave

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Married

6-DATE OF BIRTH,

Dec 12, 1918
(Month) (Day) (Year)

7-AGE,

1 yr., 5 mos., 27 da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Balt., City.

PARENTS.

10-NAME OF FATHER,

Nathan Broughlin

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Annie Jones

13-BIRTHPLACE OF MOTHER

(State or Country),

Balt. City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Nathan Broughlin

(Address).

2620 Frederick Ave

15-

MAY 13 1920

Robert P. Harrison,

101

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 12, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

opsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion
due to feeding

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) James M. Tenen M. D.
(Coroner.)

May 12, 1920 (Address) 7001 Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. da. In the State.... yrs. mos. da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Olivet Cem May 14th 1920

20-UNDERTAKER

ADDRESS

A. Jones

207 S. Shuck

D43132 HEALTH DEPARTMENT—CITY OF BALTIMORE D43132

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 Addison Alley, ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Viola Nally

(a) RESIDENCE. NO. 122 Addison Alley ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

Geo Nally

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Ethel Bean

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balt

14

Informant
(Address)Mrs. George Nally
122 Addison Alley

MAY 13 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-13 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 5, 1920, to May 13, 1920,

that I last saw him alive on May 13, 1920,

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Anemia,

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Intestinal Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Stephen D. Reed, M. D.

May 13 1920 (Address) 1227 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery May 14 1920

20 UNDERTAKER

ADDRESS

William Cook N. B. M.

D43133

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1633 Rosedale ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1633 Rosedale St.; 60 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. widowed
(Write the word.)6-DATE OF BIRTH, 1857
(Month) (Day) (Year)7-AGE, 73 yrs., 0 mos., 0 ds. If LESS than 1 day, 0 hrs. or 0 min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), Ireland10-NAME OF FATHER, Mr. Clay11-BIRTHPLACE OF FATHER (State or Country), Ireland12-MAIDEN NAME OF MOTHER, Miss Duggan13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Mr. P. H. Harrison(Address), 1633 Rosedale

15-

Robert P. Harrison,

191. Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 10, 1920
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1920, to May 10 1920, that I saw her alive on May 9 1920, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Dissected Pneumonia(Duration) 2 yrs., 0 mos., 0 ds.CONTRIBUTORY Arterio Sclerosis
(Secondary)(Duration) 10 yrs., 0 mos., 0 ds.(Signed) W. D. M. H. H. M. D.May 10/1920, 191... (Address) 8402 E. 1st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER ADDRESS

MAY 13 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43134

CERTIFICATE OF DEATH.

104 D43134
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2014 Division ST.; 14 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2014 Division St.; 1 yrs., 8 mos., — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE, <u>Colored</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <u>Single</u> (Write the word.)
6-DATE OF BIRTH, <u>Sept 13</u> , 1918 (Month) (Day) (Year)		
7-AGE, <u>1</u> yrs., <u>8</u> mos., <u>—</u> ds.		If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country), Baltimore Md.

10-NAME OF FATHER, Carroll Day
11-BIRTHPLACE OF FATHER (State or Country), Mt Vernon Md
12-MAIDEN NAME OF MOTHER, Clara Scott
13-BIRTHPLACE OF MOTHER (State or Country), Westmoreland Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Clara Day
(Address) 2014 Division

15-
Robert P. Harrison,
May 13 1920 191..... 191.....
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 13, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 9th 1920, to May 13 1920, that I saw her alive on May 12 1920, and that death occurred, on the date stated above, at 8:45 a.m. The CAUSE OF DEATH* was as follows:

Acute Catarrh of the
..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY Schistosomiasis
(Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) Edmund P. Harrison, Jr. M. D.

May 13, 1920 (Address) 1329 7th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Northwood Cemetery May 14, 1920

20-UNDERTAKER ADDRESS

Grover Holland 1631 Arundel
Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43135

D43135

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 CanalST. 11

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan Taylor(Residence in Baltimore: No. 205 CanalSt. 25 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH,

— — 1867
(Month) (Day) (Year)

7-AGE,

53 yrs. — mos. — ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laundress 0419-BIRTHPLACE, (State or Country), Richmond Va10-NAME OF FATHER, John Taylor11-BIRTHPLACE OF FATHER (State or Country), Virginia12-MAIDEN NAME OF MOTHER Susan J. Robinson13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie Taylor(Address) 205 Canal St

15-

Robert P. Harrison,Filed 3 1920

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 13th 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from May 6th 1920, to May 13 1920, that I saw her alive on May 12 1920, and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus and
bladder (Duration) 5 yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary)

Cardiac Disease (Duration) 7 yrs. — mos. — ds.(Signed) Edmund C. Harrison, M. D.May 13, 1920 (Address) 1339 N. North St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Forest HillDATE OF BURIAL, May 16 192020-UNDERTAKER Grover H. HollandADDRESS 631 N. North St.

D43136

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43136

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST.: *7* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *Dr. French A. Smith*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) *Bullins Hb.*

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec. 17, 1872*7 AGE *47* Years

Months

4 Months

26 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

South Carolina

10 NAME OF FATHER

Redding Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

South Carolina

12 MAIDEN NAME OF MOTHER

Gallie Spivy

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

North Carolina

14

Informant (Address)

Hospital Records

15

FRI

*MAY 14 1920**ROBERT B. KALSHOFER**DEPT. OF HEALTH Registrar*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 13, 1920*

17

I HEREBY CERTIFY, That I attended deceased from *May 4*, 1920, to *May 13*, 1920, that I last saw him alive on *May 13*, 1920, and that death occurred, on the date stated above, at *8 P. m.*

The CAUSE OF DEATH* was as follows:

*Chronic Nephritis*Approximate (duration) *2* yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Uræmia(duration) — yrs. — mos. *14* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. Schumacher

M. D.

19

(Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Bullins S B

20 UNDERTAKER

*J. Ahrens**May 13 1920*
ADDRESS*221 N. Carey*

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43137

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3414 Norwood Ave. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Virginia Royston Carrick

(Residence in Baltimore: No.

3414 Norwood Ave St.; 75 yrs., 7 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH,

Sept 27, 1844

(Month)

(Day)

(Year)

7-AGE,

75 yrs. 7 mos. 15 ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House duties

D37

9-BIRTHPLACE,
(State or Country),

Baltimore Md

PARENTS.

10-NAME OF FATHER,

Enoch Miller

11-BIRTHPLACE OF FATHER
(State or Country)

Baltimore Md

12-MAIDEN NAME OF MOTHER

Lydia Royston

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

M. J. Carrick

(Address)

3414 Norwood Ave

15-

MAY 14 1920

ROBERT B. KRAUTER

Baltimore City Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 12, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 8-1920, to May 12-1920,

that I saw her alive on May 12-1920,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Senile Arterio Sclerosis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Cerebral Hemorrhage

(Signed) W. K. Skilling M. D.

May 12, 1920 (Address) 4127 Hilling Heights

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Baltimore Cemetery May 14, 1920

20-UNDERTAKER

ADDRESS

John O'Donnell Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43138

CERTIFICATE OF DEATH.

37

D43138

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 538 W. LeeST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edna Foster(a) RESIDENCE. NO. 538 W Lee

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Col.

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 4th 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

9

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Samuel Foster

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Charney Patterson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant (Address)

Samuel Foster
538 W Lee

15

Filed MAY 14 1920

ROBERT B. KRAUTER

Registrar

Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5/13/1920

17

I HEREBY CERTIFY, That I attended deceased from

5/12/1920 to 5/13/1920

that I last saw him alive on 5/13/1920

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Infantile convulsions

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Clinical

(Signed)

5/14/1920 (Address)

J. H. Bortley, M. D.
908 5th Ave St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn

May 14 1920

20 UNDERTAKER

ADDRESS 143

J. H. Bortley

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43139

CERTIFICATE OF DEATH.

146 D43139

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3910 Dalrymple ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Greeley Freeman Jr(a) RESIDENCE. NO. 3910 Dalrymple ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13 19207 AGE Years Months Days If LESS than 1 day, hrs. or min. 3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) None(c) Name of employer None9 BIRTHPLACE (city or town) Baltimore (State or country) Ind.10 NAME OF FATHER Henry S Freeman11 BIRTHPLACE OF FATHER (city or town) Ind. (State or country) Barroll Co12 MAIDEN NAME OF MOTHER Milda S Heggen13 BIRTHPLACE OF MOTHER (city or town) Balt. (State or country) Ind.14 Informant Mr Charles R Freeman(Address) 3910 Dalrymple15 Filed MAY 14 1920 ROBERT F. LAUTER Registrar

Baltimore Health Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 192017 I HEREBY CERTIFY, That I attended deceased from April 27, 1920, to May 13, 1920.that I last saw him alive on May 13, 1920.and that death occurred, on the date stated above, at 11.15 a. m.

The CAUSE OF DEATH* was as follows:

Pyæmia(duration) yrs. mos. ds. 7CONTRIBUTORY (Secondary) Maxillary Abscess(duration) yrs. mos. ds. 16

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 2-1920Was there an autopsy? NoWhat test confirmed diagnosis? Operation(Signed) E. B. Duff, M. D.19 (Address) 2224 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn CemeteryMay 15 1920

20 UNDERTAKER

ADDRESS

H. M. Rountree2238 N. Milborne

TION is very important. See instructions on back of certificates.

D43140

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43140

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701-10th St. ST. 15 WARD)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Pavery Murray(a) RESIDENCE. NO. 1701-10th St. ST. 15 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 5 mos. 5 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of Elizabeth Murray

(or WIFE of)

6 DATE OF BIRTH (month, day, and year) Sept 28th 1860

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

54814

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Coff Editor

(b) General nature of industry, business, or establishment in which employed (or employee)

Government Printer

(c) Name of employer

U. S. Government9 BIRTHPLACE (city or town) Catoonsville
(State or country) Maryland10 NAME OF FATHER Thomas Murray

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland12 MAIDEN NAME OF MOTHER Louisa Herbert

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14

Informant Harry J. Arbuthnot(Address) 3018 Presbury St. Baltimore

15

MAY 14 1920

ROBERT A. LEASTER
Registrar

Burial permit 0108

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14th 1920

17

HEREBY CERTIFY, That I attended deceased from

Feb. 12th 1920, to May 14th 1920that I last saw him alive on May 13th 1920and that death occurred, on the date stated above, at 2:45 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver and Colon

(duration)

yrs. 3mos. 2ds. 2

CONTRIBUTORY (Secondary)

(duration)

yrs. 2mos. 2ds. 2

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of _____Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Garrison Marks M. D.19 (Address) 3018 Presbury St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Louder ParkMay 15 1920

20 UNDERTAKER

Geo. J. Smith

ADDRESS

400 W. Fayette St.

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43141

CERTIFICATE OF DEATH.

X 91

D43141

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1*)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *9* mos.ds. How long in U. S., if of foreign birth? *40* yrs. mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST.

WARD.

Virginia

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

N

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

None

6 DATE OF BIRTH (month, day, and year)

Aug 17, 1857

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*168**08**26*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Teacher 168

(b) General nature of industry, business, or establishment in which employed (or employer)

Mt St Josephs College

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Thos L O'Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Elizabeth O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

*Bro Jones**Mt St Josephs College**ROBERT A. L. JONES*

MAY 14 1920

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 13 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

May 10th 19 *20*, to *May 12* 19 *20*.that I last saw him alive on *May 12* 19 *20*.and that death occurred, on the date stated above, at *4 a* m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *2* da.

18 Where was disease contracted

If not at place of death?

Yes

Did an operation precede death?

No

Was there an autopsy?

What test confirmed diagnosis?

Ordinary

(Signed)

H. A. Hill

M. D.

5/3, 19 *20* (Address)*Longfellow*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Mary's Cathedral Cem.**May 15* 19 *20*

20 UNDERTAKER

ADDRESS

*F. A. Thomas & Son**703 N. E. Ave.*

TION is very important. See instructions on back of certificates.

D43142

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43142

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 Robinson ST.: 1 WARD)2-FULL NAME Mollie Little(a) RESIDENCE. No. 30 S. Robinson ST.: 1 WARD.(Usual place of abode)
Length of residence in city or town where death occurred 56 yrs. 2 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Divorced5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm W. Little6 DATE OF BIRTH (month, day, and year) Feb 15-18647 AGE Years 56 Months 2 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)10 NAME OF FATHER Jacob Waidner11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)12 MAIDEN NAME OF MOTHER don't know13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14

Informant Melvin Little (Address) 620 South East ave.

15

MAY 14 1920

ROBERT E. FRANTZ Registrar

Baltimore Health Dept

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 192017 I HEREBY CERTIFY, That I attended deceased from April, 1919, to May, 1920, that I last saw him alive on May 11, 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

DiabetesCONTRIBUTORY (Secondary) Exhaustion (duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinically(Signed) R. H. Campbell, M. D.1920 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western CemeteryMay 15 1920

20 UNDERTAKER

ADDRESS

F. A. Krause & Son703 Hanover

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43143

CERTIFICATE OF DEATH.

79

D43143

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

3732 Roland Ave. ST.: 13 WARD)

2-FULL NAME

Edgar Gilgman Reynolds

(a) RESIDENCE. NO.

3732 Roland Ave. ST.: 13 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

13 yrs. 11 mos. 10 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 3-1906

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

13

11

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

At Home

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore,

Maryland

10 NAME OF FATHER

Harry C. Reynolds

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Emma B. Rowley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Maryland

14

Informant
(Address)Harry C. Reynolds
3732 Roland Ave.

15

Filed

MAY 14 1920

ROBERT A. LAUTER
Registrar

Printed Permit Order

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 13 1920.

17

I HEREBY CERTIFY, That I attended deceased from:

June 26 - 1918, to May 13 - 1920.

that I last saw him alive on May 12 1920.

and that death occurred, on the date stated above, at 440 A. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease
with much hypertrophy

(duration) 4 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. Jones M. D.

19 (Address) 720 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery

May 15 1920.

21 UNDERTAKER

ADDRESS

Horace Burgeon

363 Hall Rd.

CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43144

CERTIFICATE OF DEATH.

H5 D43144

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kazmir Jankowski(a) RESIDENCE. No. 1916 S. Alice Ann St. ST. WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widower5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 18807 AGE 40 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) Poland
(State or country)10 NAME OF FATHER Alec Jankowski11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)14 Informant Hospital Records(Address) New City Hospital15 ROBERT I. KRAUTER MAY 14 1920
Registrar

Burial Permit (Over)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1920

17

I HEREBY CERTIFY, That I attended deceased from
April 19, 1920, to May 13, 1920.that I last saw him alive on May 13, 1920.and that death occurred, on the date stated above, at 10:00 A.M.

The CAUSE OF DEATH* was as follows:

Sarcoma of Lung + mediastinal glands.(duration) yrs. 3 mos. ds.CONTRIBUTORY Metastases to Liver
(Secondary)(duration) yrs. 2 mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? no special test(Signed) J. J. P. P. M. D.May 13, 1920 Address New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary7/14 1920

20 UNDERTAKER

ADDRESS

Wm. Ziackowski 1618 Eastern

TION is very important. See instructions on back of certificates.

D43145

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43145

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 440 W. Lakewood Ave. WARD) 6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Annice Hanson

(a) RESIDENCE. NO.

440 W. Lakewood Ave 6 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofThe late Chas. Hanson

6 DATE OF BIRTH (month, day, and year)

March 1861

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

5916

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town)

Balto. Md.

(State or country)

10 NAME OF FATHER

Joseph Marguerite

11 BIRTHPLACE OF FATHER (city or town)

Germany

(State or country)

12 MAIDEN NAME OF MOTHER

Lena Rasche

13 BIRTHPLACE OF MOTHER (city or town)

Germany

(State or country)

14

Informant
(Address)Lilly & Zieher
403 S. Mifflin St.

15

MAY 14 1920

ROBERT H. PEABODY

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1920

17

I HEREBY CERTIFY, That I attended deceased from

5-9, 1920, to 5-12, 1920,that I last saw her alive on 5-12, 1920,and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration)

yrs.

mos.

3

ds.

CONTRIBUTORY
(Secondary)Bright's Disease

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Elijah J. Russell

M. D.

19

(Address)

156 N. Mifflin Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral CemeteryMay 15 1920

20 UNDERTAKER

Lilly & Zieher

ADDRESS

403 S. Mifflin St.

TION is very important. See instructions on back of certificates.

D43146

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43146

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1840 N. Saratoga* ST. *20* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *1840 N. Saratoga* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov 4th 1865*7 AGE Years *54* Months *6* Days *7* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md.*10 NAME OF FATHER *John E. Reifert*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Mary Schwinn*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant *John H. Meagher* (Address) *1840 N. Saratoga St.*

15 MAY 14 1920 ROBERT E. KAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 13 1920*17 I HEREBY CERTIFY, That I attended deceased from *April 17* 1920 to *May 13* 1920 that I last saw him alive on *May 12* 1920and that death occurred, on the date stated above, at *440 A* m.

The CAUSE OF DEATH* was as follows:

*Hemiplegia**over*(duration) yrs. mos. *26* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *W. G. Smith* M. D.*May 13 1920* (Address) *118 N. Calhoun St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cathedral Cemetery**5-15 1920*

20 UNDERTAKER

ADDRESS

*James Dignam & Son**1000 S. Beach*

TION IS VERY IMPORTANT. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43147

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 Argyle Ave

ST. 17

WARD)

3-FULL NAME

Mrs. Rachel Turner

(Residence in Baltimore: No. 924 Argyle Ave

St. 17 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, Female
4-COLOR OR RACE, Cal
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widon

6-DATE OF BIRTH, Dec 11, 1856
(Month) (Day) (Year)

7-AGE, 64 yrs. mos. ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Cooking
(b) General nature of industry, business, or establishment in which employed (or employer), 5021

9-BIRTHPLACE, (State or Country), Howard Co., Md

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Turner

(Address) 924 Argyle Ave

15-

Filed MAY 14 1920

ROBERT A. BRAUTER

BALTIMORE CITY REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3-1-20 191, to 5-12-20 191

that I saw her alive on 4 191

and that death occurred, on the date stated above, at 5:10 P.M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY Chronic Pleurisy

(Duration) yrs. mos. ds.

(Signed) J. E. Cardozo M. D.

5-12-20 191 (Address) 1524 O'Hill Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

Mt. Auburn Cem. May 16, 1920

20-UNDERTAKER

ADDRESS

Charles B. Jones 211 Pine

D43148

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43148

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 East ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 221 East ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? 39 yrs. 5 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Co 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day, and year) Jan 4 1881

7 AGE Years 39 Months 5 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 086(b) General nature of industry, business, or establishment in which employed (or employer) Jail(c) Name of employer Gutman9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Jos. Boom11 BIRTHPLACE OF FATHER (city or town) Chester Co Md (State or country)12 MAIDEN NAME OF MOTHER Elizabeth Evans13 BIRTHPLACE OF MOTHER (city or town) Chester Co Md (State or country)

14

Informant (Address) Richard Boom 821 Reaborg

15

File

MAY 14 1920

ROBERT A. BAUTER Registrar

Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Apr 28 1920 to May 11 1920 that I last saw him alive on May 11 1920 and that death occurred, on the date stated above, at 11:50 P.M. The CAUSE OF DEATH* was as follows: Interstial Nephritis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Regular(Signed) F. B. Gutman M. D.(Address) 1313 W North St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 114

D43149

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43149

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Trasmak(a) RESIDENCE, No. 408 13th st.
(Usual place of abode) UnknownST. 26 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofGeorge Trasmak6 DATE OF BIRTH (month, day, and year) 18987 AGE Years Months Days If LESS than 1 day, hrs. or min.
22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Austria

10 NAME OF FATHER

John Sultan11 BIRTHPLACE OF FATHER (city or town)
(State or country)Austria12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Unknown

14

Informant
(Address)Hospital Records
M.T.H.

15

MAY 14 1920ROBERT A. BRAUTER
Registrar
Burial Permit 0161

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13th 192017 I HEREBY CERTIFY, That I attended deceased from
April 19th, 1920, to May 13th, 1920,
that I last saw her alive on May 12th, 1920,
and that death occurred, on the date stated above, at 7.50 a.m.
The CAUSE OF DEATH* was as follows:Pulmonary tuberculosis(duration) 3 yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in Sputum(Signed) George R. Wilkerson, M. D.5-14-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Rt. Stanislaus5/17-1920

20 UNDERTAKER

ADDRESS

W. F. Sadowski, 705 S. Lane

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43150

D43150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 Arlington Ave. ST. 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Elizabeth Bowen(Residence in Baltimore: No. 717 Arlington Ave. St.; 60 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE

Widow
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Sept 10, 1844
(Month) (Day) (Year)

7-AGE,

75 yrs., 0 mos., 0 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Ms.ood9-BIRTHPLACE,
(State or Country),Balto.

10-NAME OF FATHER,

Abel Heim11-BIRTHPLACE OF FATHER
(State or Country),Germany

12-MAIDEN NAME OF MOTHER

Elyia Baker13-BIRTHPLACE OF MOTHER
(State or Country),Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

MAY 14 1920

ROBERT B. KRAUTER

BURIAL FORM

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 13, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 6, 1920, to May 13, 1920,that I saw her alive on May 12, 1920,and that death occurred, on the date stated above, at 9:30 m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
To my knowledge 3 yrs., 0 mos., 0 ds.CONTRIBUTORY
(Secondary)(Duration) 3 yrs., 0 mos., 0 ds.(Signed) Mary F. Viegles, M. D.May 12, 1920 (Address) 1028 W. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London ParkMay 17, 1920

20-UNDERTAKER

ADDRESS

C. A. WiedefeldSumner

important. See instructions on back of certificate.

Georgeanna B. Simmons
HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D43152

CERTIFICATE OF DEATH.

74 D43152
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Protestant Infirmary* ST.; *15* WARD)

2-FULL NAME

(Residence in Baltimore: No. *2934 Westwood Ave.* St.; *10* yrs., *10* mo., *10* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

Oct. 21, 1891.
(Month) (Day) (Year)

7-AGE,

28 yrs., *6* mos., *21* ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer). *607*

9-BIRTHPLACE, (State or Country),

Pa

10-NAME OF FATHER,

Geo. Baer

11-BIRTHPLACE OF FATHER (State or Country),

Pa.

12-MAIDEN NAME OF MOTHER

Anna Thompson

13-BIRTHPLACE OF MOTHER (State or Country),

md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss E. H. Baer*(Address) *2934 Westwood Ave.*

15-

Filed

MAY 14 1920

ROBERT B. KRAUTER

Burial Form 1-10-1918

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 12, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 7, 1920, to May 12, 1920.*that I saw her alive on *May 12, 1920.*and that death occurred, on the date stated above, at *5:40* m.

The CAUSE OF DEATH* was as follows:

Respiratory failure(Duration) *7* yrs., *10* mos., *10* ds.

CONTRIBUTORY (Secondary)

Brain Tumor
(Duration) *1* yr., *10* mos., *10* ds.(Signed) *Walter Hughes* M. D.*5-12, 1920* (Address) *1517 Division St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *10* yrs., *10* mos., *10* ds. In the State *10* yrs., *10* mos., *10* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Delta Pa

DATE OF BURIAL

May 15, 1920

20-UNDERTAKER

Joseph B. Cook

ADDRESS

1003 W. 1st St.

D43153

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43153

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3006 Belmont Ave ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth O Barker

(a) RESIDENCE. No. 3006 Belmont Ave ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Hugh J. Barker

6 DATE OF BIRTH (month, day, and year)

Aug. 17-1852

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

68

8

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Liverpool England

10 NAME OF FATHER

Edw. Farrell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Eng

12 MAIDEN NAME OF MOTHER

Fiddie

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

14

Informant (Address)

H. J. Barker Jr

15

Filed

MAY 14 1920

Robert F. [unclear]

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 1st 1920 to May 12 1920

that I last saw her alive on May 13 1920

and that death occurred, on the date stated above, at 5-0 a. m.

The CAUSE OF DEATH* was as follows:

Acute Distention of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Clinical symptoms

(Signed) Wm. Beards M. D.

574, 1920 (Address)

5 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

5-16-1920

20 UNDERTAKER

ADDRESS 617 N

H. Branning Dr Schroeder St

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43154

CERTIFICATE OF DEATH.

D43154

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *708 Leroy*)ST.: *21* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *708 Leroy*

(Usual place of abode)

ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. *10* mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 13/1919

7 AGE

Years

Months

Days

10

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Geo. Terrey

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va

12 MAIDEN NAME OF MOTHER

Estella Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

14

Informant (Address)

Estella Terrey
807 Leroy St.

15

Filed

19

MAY 14 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 13th 1920

17

I HEREBY CERTIFY, That I attended deceased from

*May 6, 1920, to May 13, 1920,*that I last saw him alive on *May 12, 1920,*and that death occurred, on the date stated above, at *12* m.

The CAUSE OF DEATH* was as follows:

*own**Acute Bronchitis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Harry Boyd*, M. D.5-17-1920 Address *207 Columbia*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt Auburn**May 15 1920*

20 UNDERTAKER

ADDRESS

*Wm. Brown & Son**108 W. Mount*

TION is very important. See instructions on back of certificates.

D43155

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43155

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9)

2-FULL NAME

(a) RESIDENCE. No.

Length of residence in city or town where death occurred

St. Joseph's Hospital 9

Mrs. Margaret M. Croory

1338 N. Caroline

Unknown

ST. WARD.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Thos. Mc Croory

6 DATE OF BIRTH (month, day, and year)

June 1888

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

62

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Thos. O'Neill Co

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

James Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Margaret Dougherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Mrs. H. Harrison
1338 N. Caroline St.
Robert T. Harrison,

MAY 14 1920

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5/14 1920

17 I HEREBY CERTIFY, That I attended deceased from
 Apr. 22, 1920, to May 14, 1920,
 that I last saw her alive on May 14, 1920,
 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of gall bladder
 and gall ducts

(duration) yrs. 3 mos. 6 ds.

CONTRIBUTORY (Secondary)

Myocardial Insufficiency

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Apr. 23, 1920

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Howard D. McChesney, M. D.

19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cem

5/17 1920

20 UNDERTAKER

ADDRESS

Chas. E. Evans & Son, 118 N. Mt Royal Ave

D43156

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43156

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: Municipal Tuberculosis Hospital 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levi Colston(a) RESIDENCE. NO. Non-resident

(Usual place of abode)

Unknown

ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

MaleColoredSingle5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1858

7 AGE

Years

Months

Days

If LESS than
1 day,.....hrs.
or.....min.62

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workLaborer(b) General nature of industry,
business, or establishment in
which employed (or employer)Unknown

(c) Name of employer

Unknown9 BIRTHPLACE (city or town)
(State or country)Virginia

10 NAME OF FATHER

Carl Colston11 BIRTHPLACE OF FATHER (city or town)
(State or country)Virginia

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Virginia

14

Informant
(Address)Hospital RecordsM.T.H.

UNIVERSITY OF MARYLAND

15

Filed

Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11th 1920

17

I HEREBY CERTIFY, That I attended deceased from
April 24, 1920, to May 11th, 1920that I last saw him alive on May 10th, 1920and that death occurred, on the date stated above, at 3.50 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 1 yrs.mos.ds.CONTRIBUTORY Chronic nephritis
(Secondary)(duration) Unknown yrs.mos.ds.

18 Where was disease contracted

If not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

George R. Wilkerson, M. D.5-11-20 Address Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner Health.MAY 14 1920

OFF. OF H. HEALTH

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43157

D43152

CERTIFICATE OF DEATH. *Leach 104*

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mrs. Ross* ST.: *18* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Baby Josephine Leach*(a) RESIDENCE. NO. *Mrs. Ross* ST.: *18* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *11* mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *?*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore*

14

Informant (Address) *Robert P. Harrison,*

UNIVERSITY OF MARYLAND

15

Filed *14* 1920 *14* 1920 *14* 1920

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *4/21* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from *4/21* 19 *20* to *4/22* 19 *20* that I last saw him alive on *4/22* 19 *20* and that death occurred, on the date stated above, at *1.15* p. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *John D. Ridge* M. D.5/2, 1920 (Address) *Mrs. Ross*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner Health.

MAY 1 1920

TION is very important. See instructions on back of certificates.

D43158

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43158

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 Cypress St. Cuth. Bay 25 ST. 25 WARD)

REGISTERED NO. C _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Osborne

(Residence in Baltimore: No. _____ St.; _____ yrs., _____ mos. _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M.4-COLOR OR RACE, W.5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, May 13, 1920

(Month)

(Day)

(Year)

7-AGE, _____

_____ yrs. _____ mos. _____ ds.

If LESS than 1 day,

_____ hrs. or 30 min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) _____

9-BIRTHPLACE, (State or Country), Maryland10-NAME OF FATHER, Lawrence Dudley Osborne11-BIRTHPLACE OF FATHER (State or Country), Va.12-MAIDEN NAME OF MOTHER Lula Virginia Coleman13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. O. Osborne(Address) 19 Cypress

15-

Filed MAY 14 1920Robert P. Harrison,

101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 13, 1920

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from May 13 1920, to May 13 1920,that I saw him alive on May 13 1920,and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth
Miscarriage 6 mo. gest.
(Duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Geo. B. Davis M. D.May 13, 1920 (Address) 211 Church St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITALDATE OF BURIAL, _____, 1920

20-UNDERTAKER _____

ADVIS _____

MAY 14 1920

Commissioner Health.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43159

CERTIFICATE OF DEATH.

D43159

1-PLACE OF DEATH

Little Sisters of the Poor

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary M. G. Wilson

(Residence in Baltimore: No.

Little Sisters of the Poor

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Old

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Wid

6-DATE OF BIRTH.

Feb 14, 1850

7-AGE,

70 yrs., 3 mos., ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

Jeremiah Chaplin

11-BIRTHPLACE OF FATHER, (State or Country),

Don't Know

12-MAIDEN NAME OF MOTHER

Alice Marie Denois

13-BIRTHPLACE OF MOTHER, (State or Country),

Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lisbeth Benedict

(Address)

Little Sisters of the Poor

15-

MAY 14 1920

Robert P. Harrison,

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 14, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

to receive

191

to

191

that I saw her alive on May 13, 1920,

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

Infection (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Harrison, M. D.

May 14, 1920 (Address) 1133 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2, mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross

May 15, 1920

20-UNDERTAKER

ADDRESS

H. C. Needelfeld 914 Greenmount Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43160

CERTIFICATE OF DEATH.

D43160

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mrs. Hosh*)ST. *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Theodore Payleitner

(a) RESIDENCE. NO.

(Usual place of abode)

ST. *11* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

13 yrs. *4* mos. *12* ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*13**4**12*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

*Hospital Records**Robert P. Harrison,*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 13 1920

17

I HEREBY CERTIFY, That I attended deceased from

, 19 , to , 19 ,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at , m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*George J. J. J.**May 15 1920*

TION is very important. See instructions on back of certificates.

MAY 14 1920

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

D43161

CERTIFICATE OF DEATH

X 28

D43161

PLACE OF DEATH

Mura

REGISTERED No. C

CITY OF BALTIMORE (No.

713 Mura

ST. 10 WARD)

FULL NAME

Catherine E. Shanley

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

713 Mura

St.: yrs. 2 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

White

SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

yes

DATE OF BIRTH

July

22, 1870

AGE

49

yrs.

9

mos.

21

ds.

If LESS than

1 day, 2 hrs.

or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

BIRTHPLACE

(State or country)

Nebraska Ill

NAME OF FATHER

John A. Honell

BIRTHPLACE OF FATHER

(State or country)

Ireland

MAIDEN NAME OF MOTHER

Fannie Carroll

BIRTHPLACE OF MOTHER

(State or country)

Ireland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry A. Shanley

(Address)

5110 Park St. Baltimore

15

Robert P. Harrison,

191

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

May

14

1920

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 2

1920

to

May 13

1920

that I saw him alive on

May 13

1920

and that death occurred, on the date stated above, at

8:40

The CAUSE OF DEATH* was as follows:

Pulmonary & Laryngeal
Tuberculosis

Contributory

(SECONDARY)

Exhaustion

(Signed)

H. H. Hobart

M. D.

May 17, 1920

(Address) 219 N. Colman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

Where was disease contracted?

If not at place of death?

Former or

usual residence

In the

State

Where was disease contracted?

If not at place of death?

Former or

usual residence

yrs.

mos.

ds.

yrs.

mos.

ds.

At place

of death

Where was disease contracted?

If not at place of death?

Former or

usual residence

Statenville Ohio

19-PLACE OF BURIAL OR REMOVAL

Statenville Ohio

DATE OF BURIAL

May 15, 1920

20-UNDERTAKER

Chenoweth Son

ADDRESS

Chestnut Ave

D43162

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43162

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 N. Fremont Ave. ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John W. Bubert

(a) RESIDENCE NO.

809 N. Fremont Ave.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

WIFE of

Grace M. Bubert

6 DATE OF BIRTH (month, day, and year)

May 23, 1854

7 AGE

Years

65

Months

6

Days

21

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer)

U.S. Post Office

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

John S. Bubert

11 BIRTHPLACE OF FATHER (city or town)

Germany

(State or country)

12 MAIDEN NAME OF MOTHER

Mary C. Truimpf

13 BIRTHPLACE OF MOTHER (city or town)

Germany

(State or country)

14

Informant

(Address)

Dr. John S. Bubert

1500 N. Park Ave.

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 5, 1920, to May 14, 1920,

that I last saw him alive on May 14, 1920,

and that death occurred, on the date stated above, at 8:15 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no test

(Signed) Chas. H. Bubert, M. D.

5/14, 1920 (Address) 1100 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park Cemetery

May 17 1920

20 UNDERTAKER

ADDRESS 1920

Harry W. Ehlert

W. Norton

TION is very important. See instructions on back of certificates.

MAY 14 1920

40 61 **D43163****HEALTH DEPARTMENT—CITY OF BALTIMORE****D43163****CERTIFICATE OF DEATH.****1-PLACE OF DEATH**CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *27* WARD)**REGISTERED NO.**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Anna Johnson***(a) RESIDENCE.** No. *459 S. Maryland St.* WARD.

(Usual place of abode)

(If nonresident give city and State)

Length of residence in city or town where death occurred *2* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX <i>Female</i>	4 COLOR OR RACE <i>Colored</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Single</i>
------------------------	-----------------------------------	---

6a If married, widowed, or divorced -
HUSBAND of
(or) WIFE of*Single*6 DATE OF BIRTH (month, day, and year) *Nov 18-1879*

7 AGE <i>40</i>	Years	Months <i>5</i>	Days <i>25</i>	If LESS than 1 day, hrs. or min.
--------------------	-------	--------------------	-------------------	--

8 OCCUPATION OF DECEASED(a) Trade, profession or particular kind of work *Homemaker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Maryland*
(State or country)10 NAME OF FATHER *James Johnson*11 BIRTHPLACE OF FATHER (city or town) *Md.*
(State or country)12 MAIDEN NAME OF MOTHER *Frances Carey*13 BIRTHPLACE OF MOTHER (city or town) *Md.*
(State or country)14 Informant *Hospital Record*
(Address) *Robert T. Harrison*15 *14* *1920* Burial Permit Clerk. Registrar**MEDICAL CERTIFICATE OF DEATH**16 DATE OF DEATH (month, day, and year) *May 13 1920*

17 I HEREBY CERTIFY, That I attended deceased from *May 12*, 19*20*, to *May 13*, 19*20*, that I last saw her alive on *May 13*, 19*20*, and that death occurred, on the date stated above, at *12:50* p. m.

The CAUSE OF DEATH* was as follows:

*Myomete Uteri -*CONTRIBUTORY
(Secondary)

(duration) *1* yrs. *6* mos. *da.*
Surgical Shock
(duration) yrs. mos. da.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *Yes* Date of *May 13, '20*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *H. H. Shaw*

M. D.

19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Jim Gutz *May 16 1920*
George H. Holland *1631 Ken*

TION is very important. See instructions on back of certificates.

D43161

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43161

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Scott(a) RESIDENCE. No. 505 W. 29th st.ST. Unknown WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

Colored

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Elevator boy

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

William Scott

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Susie Barrell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant (Address)

Hospital Records
M. T. H.

15

Filed

Robert P. Harrison

Registrar

MAY 15 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13th 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 20th, 19 20, to May 13th, 19 20,that I last saw him alive on May 13th, 19 20,and that death occurred, on the date stated above, at 3.55 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Unknown

Did an operation precede death? No Date of

Was there an autopsy?

(ray.)

What test confirmed diagnosis? T. B. in sputum & X-

(Signed)

George R. Wilkinson, M. D.

5-13-20

Address Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

John H. TreadwellMay 15 1920

D43165

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43165

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1341 Fremont Ave. ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Marie Wright

(a) RESIDENCE. NO.

1341 Fremont Ave. ST. 14 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

Aug 22, 1918

7 AGE

1

Years

Months

8

Days

21

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

Charles Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Not known

12 MAIDEN NAME OF MOTHER

Nellie White

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Nellie White
1341 Fremont Ave.

15

MAY 15 1920

Robert F. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 13 1920

17

I HEREBY CERTIFY, That I attended deceased from May 8, 1920, to May 13, 1920, that I last saw her alive on May 13, 1920, and that death occurred, on the date stated above, at 5 P. m. The CAUSE OF DEATH* was as follows:Broncho Pneumonia
(primary)(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No(Signed) E. William Frey, M. D.7/14, 1920 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Catholic CemeteryMay 15 1920

20 UNDERTAKER

ADDRESS

Joseph A. Farrell31 Division

TION is very important. See instructions on back of certificates.

D43166

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43166

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 436 Calvin Ave ST.; 12 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 436 Calvin Ave St. 12 yrs. 1 mos. 5 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH

April 9th, 1854
(Month) (Day) (Year)

7-AGE,

66 yrs. 1 mos. 5 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Liggett & Porter
0179-BIRTHPLACE,
(State or Country),

MD.

10-NAME OF FATHER,

Samuel Burnham

11-BIRTHPLACE OF FATHER

(State or Country),

MD.

12-MAIDEN NAME OF MOTHER

Sophia Hopkins

13-BIRTHPLACE OF MOTHER

(State or Country),

MD.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Martha Burnham(Address) 436 Calvin Ave.

15-

Filed May 15 1920 191. Robert P. Harrison,

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 14th, 1920
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from Dec 31st 1920, to May 14th 1920,that I saw him alive on May 14th 1920and that death occurred, on the date stated above, at 4:15 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(Duration) ... yrs. 10 mos. ... ds.

CONTRIBUTORY

(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed)

Geo W. Morgan M. D.
May 14th 1920 (Address) 401 E 25th St

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL,

May 17, 1920

20-UNDERTAKER

Robt P Turner & Co

ADDRESS

1442 Broadway

D43167

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43167

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 S. Bentalou St. ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Reese(a) RESIDENCE. NO. 417 S. Bentalou St. ST. 20 WARD. (If nonresident give city or town and State)Length of residence in city or town where death occurred 72 yrs. 6 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John S. Reese

6 DATE OF BIRTH (month, day, and year) Nov. 10, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER George Allen Mills

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah Crew

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

14 Informant Margaret E. Armstrong
(Address) 417 S. Bentalou St.

15 Filed 1920 19 Registrar Robert F. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Apr 2 19 20, to May 14 19 20, that I last saw him alive on May 13 19 20 and that death occurred, on the date stated above, at 1:50 m.

The CAUSE OF DEATH* was as follows:

Toxaemia(duration) 1 yrs. 14 ds.

CONTRIBUTORY

(Secondary) Carcinoma of Esophagus

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Examination(Signed) Howard Kalin M. D., 19 (Address) 2027 North St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Christ ChurchMay 17 1920

20 UNDERTAKER

ADDRESS

Joseph B. Cook1003 N. E. St.

THIS IS VERY IMPORTANT. See instructions on back of certificates.

D43168

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 S. Poppleton ST.; 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Elizabeth S. Forrester(Residence in Baltimore: No. 111 S. Poppleton St.; 59 yrs., 4 mos., 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, married (Write the word.)6-DATE OF BIRTH, Dec 22nd, 1861 (Month) (Day) (Year)7-AGE, 59 yrs., 4 mos., 20 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housewife (b) General nature of industry, business, or establishment in which employed (or employer), 0379-BIRTHPLACE, (State or Country), Baltimore, Md.10-NAME OF FATHER, Joshua V. P. Dick11-BIRTHPLACE OF FATHER (State or Country), Maryland12-MAIDEN NAME OF MOTHER, L. Layman13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Sarah A. Kirby(Address), 111 S. Poppleton St.

15- Robert P. Harrison, Registrar.

Filed May 15 1920, 191.....

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH May 12, 1920 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Jan 1st 19120, to May 12 1920, that I saw her alive on May 11th 19120, and that death occurred, on the date stated above, at 6:27 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bowell (Duration)..... yrs..... mos..... ds.CONTRIBUTORY (Secondary) Cancer of the lungs (Duration)..... yrs..... mos..... ds.(Signed) John S. Forrester M. D. 5/15/20 (Address) 888 N. Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem DATE OF BURIAL, May 17, 192020-UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Calver St.

D43169

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43169

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE:

No. 1537 Ensor

ST.:

WARD) 9

2-FULL NAME

Rose. Maria. Dillmann

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

1537 Ensor

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 3 mos. 10 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Peter F. Dillmann

6 DATE OF BIRTH (month, day, and year)

Aug. 3, 1884

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

35

9

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country)

Baltimore

10 NAME OF FATHER

Francis X. Stoyler

11 BIRTHPLACE OF FATHER (city or town, State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Margaret Bunze

13 BIRTHPLACE OF MOTHER (city or town, State or country)

Baltimore

14

Informant
(Address)Mr. Peter F. Dillmann
1537 Ensor St.

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 13, 1920

17

I HEREBY CERTIFY, That I attended deceased from April 4th, 1920, to May 13th, 1920, that I last saw her alive on May 13th, 1920, and that death occurred, on the date stated above, at 6:15 P. M.

The CAUSE OF DEATH was as follows:

Chronic Parenchymatous Nephritis

CONTRIBUTORY (Secondary)

(duration) 6 yrs. 6 mos. ds. I don't know of any

18 Where was disease contracted if not at place of death?

I don't know

Did an operation precede death?

No Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Urinalysis

(Signed)

J. B. Schwabach, M. D.

19

(Address)

812 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cemetery

May 17, 1920

20 UNDERTAKER

ADDRESS

Jenny Stock Sur

1301 E. Epp

TION is very important. See instructions on back of certificates.

MAY 15 1920

D43170

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1603 E Chase*ST.: *7*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Henry Dietz*(a) RESIDENCE. NO. *1603 E Chase*

(Usual place of abode)

ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *53* yrs. *1* mos. *1* ds.How long in U. S., if of foreign birth? *53* yrs. *1* mos. *1* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of *Anna Dietz*
(or WIFE of)6 DATE OF BIRTH (month, day, and year) *May 18 1849*

7 AGE

Years *70*Months *11*Days *27*If LESS than
1 day. hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of business, or establishment which employed (or employer)

Broer (Brown)

(c) Name of employer

9 BIRTHPLACE (city or town) *Bermary*
(State or country)10 NAME OF FATHER *John Dietz*11 BIRTHPLACE OF FATHER (city or town) *Bermary*
(State or country)12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) *Not known*
(State or country)

14

Informant
(Address) *Mrs Anna Dietz*
1603 E Chase

15

Filed *May 15 1920* *Robert P. Harrison,*

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 14 1920*

17 I HEREBY CERTIFY, that I attended deceased from

June 1st 1919 to *May 14 1920*that I last saw him alive on *May 13th 1920*and that death occurred, on the date stated above, at *5:30 A* m.

The CAUSE OF DEATH* was as follows:

*Gastric Carcinoma**General Anemia*
CONTRIBUTORY
*Amputation of right leg 1916*18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test results?

(Signed) *Dr. W. A. Meyer*19 (Address) *1031 N. Caroline*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Cemetery

DATE OF BURIAL

May 17 1920

20 UNDERTAKER

Henry Brock Lee

ADDRESS

1301 E. Gay

TION is very important. See instructions on back of certificates.

D43171

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43171

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1830 Byrd* ST. *24* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Nellie M. Lacher*(a) RESIDENCE. No. *1830 Charles* ST. *24* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *12* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Charles Lacher*6 DATE OF BIRTH (month, day, and year) *July 5/1888*

7 AGE

Years *32*Months *10*Days *6*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *037*(c) Name of employer *Deep*9 BIRTHPLACE (city or town) *Baltimore* (State or country) *MD*10 NAME OF FATHER *Wm. E. Eaves*11 BIRTHPLACE OF FATHER (city or town) *MD* (State or country)12 MAIDEN NAME OF MOTHER *Charles A. Kleene*13 BIRTHPLACE OF MOTHER (city or town) *MD* (State or country)

14

Informant (Address) *Chas Lacher 1830 Byrd St.*

15

Filed

19

Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 11 1920*

17

I HEREBY CERTIFY, That I attended deceased from *May 11*, 19*20*, to *May 11*, 19*20*, that I last saw him alive on *May 11*, 19*20*.and that death occurred, on the date stated above, at *9 P* m.

The CAUSE OF DEATH* was as follows:

*Periculous Anemia*CONTRIBUTORY (Secondary) *Exhaustion*(duration) yrs. *6* mos. ds.(duration) yrs. *2* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *NO* Date ofWas there an autopsy? *NO*What test confirmed diagnosis? *Clinically*(Signed) *R. H. Campbell*, M. D.18, 1920 Address) *1644 Hancock St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cedar Hill Cemetery**4/15* 19*20*

20 UNDERTAKER

ADDRESS

*Mrs. J. E. Larnach**1428 Chas.*

TION is very important. See instructions on back of certificates.

MAY 15 1920

D43172

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43172

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1202 William* ST. *24* WARD)2-FULL NAME *Edna E. Christopher*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. *1202 William* ST. *24* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May, 27, 1901*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
19 *11* *14*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto Md*
(State or country)10 NAME OF FATHER *Samuel E. Christopher*11 BIRTHPLACE OF FATHER (city or town) *Balto Md*
(State or country)12 MAIDEN NAME OF MOTHER *Agnes Shenton*13 BIRTHPLACE OF MOTHER (city or town) *Balto Md*
(State or country)14 Informant *Agnes Johnson*
(Address) *1202 William St*15 *Robert P. Harrison*
Registrar

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH (month, day, and year) *May 13 1920*

17

I HEREBY CERTIFY, That I attended deceased from *Dec 9*, 1920, to *May 13*, 1920, that I last saw *her* alive on *May 13*, 1920, and that death occurred, on the date stated above, at *1:30 P.M.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Unknown*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Reginald*(Signed) *J. E. Smith* M. D.19 Address *910 Light St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Not Alive Cemetery *4/17/1920*

20 UNDERTAKER ADDRESS

Mrs. J. E. Evans *1428 N. Charles St.*

TION is very important. See instructions on back of certificates.

MAY 15 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43173

CERTIFICATE OF DEATH.

D43173
154

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 Clarkson St. ST.: 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C Bradley(a) RESIDENCE. NO. 1732 Clarkson St. ST. 23 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds.How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Anne Bradley6 DATE OF BIRTH (month, day, and year) May 9 1872

7 AGE

Years 48Months 5Days 5

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or Country)10 NAME OF FATHER James Bradley11 BIRTHPLACE OF FATHER (city or town) Id. (State or country)12 MAIDEN NAME OF MOTHER Ann K...13 BIRTHPLACE OF MOTHER (city or town) Id. (State or country)

14

Informant Mary Anne Bradley (Address) 1732 Clarkson St.

15

MAY 15 1920 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 19 20

17

HEREBY CERTIFY, That I attended deceased from May 1, 19 20, to May 14, 19 20, that I last saw him alive on May 14, 19 20, and that death occurred, on the date stated above, at 11 m. The CAUSE OF DEATH* was as follows:Infirmities of age(duration) yrs. mos. 14 ds.CONTRIBUTORY (Secondary) Transition(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No

Date of

Was there an autopsy? NoWhat test confirmed diagnosis? Glomerular aspects(Signed) R. E. Campbell, M. D.14, 19 20 (Address) 1644 Hancock St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL At homeDATE OF BURIAL May 15 19 2020 UNDERTAKER Wm. CookADDRESS 1644 Hancock St.

D43171

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43171

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1450 Reynold ST.; 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1450 Reynold ST.; Life yrs. 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Child

6-DATE OF BIRTH,

May 14, 1920
(Month) (Day) (Year)

7-AGE,

4 1/2 yrs. 0 mos. 0 ds. 4 1/2 hrs. 0 min. 0 sec.
If LESS than 1 day, (Write the word.)

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Child
(b) General nature of industry, business, or establishment in which employed (or employer) 0009-BIRTHPLACE, (State or Country), Balto10-NAME OF FATHER, Bert Paul11-BIRTHPLACE OF FATHER (State or Country), England12-MAIDEN NAME OF MOTHER May Paul13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bert Paul(Address) 1450 Reynold Street

15-

MAY 15 1920 Robert P. Harrison,
Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 14, 1920
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from May 14 1920, to May 14 1920, that I saw him alive on May 14 1920, and that death occurred, on the date stated above, at 9:30 pm

The CAUSE OF DEATH* was as follows:

Premature
7 month gestation
(Duration) 0 yrs. 0 mos. 0 ds.CONTRIBUTORY (Secondary) Not known(Duration) 0 yrs. 0 mos. 0 ds.(Signed) Dr. R. K. Kolt M. D.(Address) 1203 Light

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

May 15, 1920

20-UNDERTAKER

William Cook

ADDRESS

583 E. North

Am

D43175

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43175

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST.: 8

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Utz(a) RESIDENCE. NO. 1575 N. Dallas St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Catherine Utz6 DATE OF BIRTH (month, day, and year) 1861

7 AGE

Years

Months

Days

If LESS than
1 day. hrs.
or min.59

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Broom maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER

Peter Utz

11 BIRTHPLACE OF FATHER (city or town)

Germany

(State or country)

12 MAIDEN NAME OF MOTHER Susan Wistall

13 BIRTHPLACE OF MOTHER (city or town)

Germany

(State or country)

14

Informant
(Address)Hospital RecordsNew City Hospital

15

Filled

19

Registrar

Robert F. Harrison
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 19 20

17

I HEREBY CERTIFY, That I attended deceased from

May 8, 19 20, to May 14, 19 20.that I last saw him alive on May 14, 19 20.and that death occurred, on the date stated above, at 10:30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Recurrent) Rt. Breast & metastasis to ribs and clavical.(duration) 2 yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? 2 Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank T. Barker, M. D.May 14 19 20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer

20 UNDERTAKER

Cro. M. Fink & Son,

Funeral Directors & Embalmers

DATE OF BURIAL

MAY 18 1920

ADDRESS

811 N. Wolfe

TION is very important. See instructions on back of certificates.

D43176

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43176

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *944 N. Collington Ave.* ST.;WARD) *7*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Florence E. Holdefer

(a) RESIDENCE. NO.

944 N. Collington Ave. ST.;

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*John H. Holdefer*

6 DATE OF BIRTH (month, day, and year)

Feb 22nd 1870

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*50**2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Balto City*

10 NAME OF FATHER

*James Easton*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*MD.*

12 MAIDEN NAME OF MOTHER

*Not Given*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Not Given*

14

Informant
(Address)*John H. Holdefer*
944 N. Collington Ave.

15

MAY 15 1920 *Robert P. Harrison,*

Registrar

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *MAY 13 1920*

17

I HEREBY CERTIFY, That I attended deceased from

May 10, 1919 to *May 13, 1920*that I last saw him alive on *May 12, 1920*and that death occurred, on the date stated above, at *2:30* p.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Chronic Interstitial Nephritis* (duration) *2* yrs. mos. ds.18 Where was disease contracted
if not at place of death?*Don't know*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

Blood pressure 280(Signed) *J. E. Harrison*, M. D.*May 13, 1920* (Address) *1301 N. Pat Park*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cem.

DATE OF BURIAL

MAY 17 1920

20 UNDERTAKER

Cec. M. Fink & Son,

ADDRESS

811 N. Wood

Funeral Directors & Embalmers.

D43172

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Blumhardt(a) RESIDENCE. No. 2716 Philadelphia Ave ST. 63 WARD. 63
(Usual place of abode) (If nonresident give city or town and State)Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18 577 AGE Years Months Days If LESS than 1 day, hrs. or min.
63

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Policeman

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town) Pennsylvania
(State or country)10 NAME OF FATHER Lewis Blumhardt11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)14 Informant Hospital Records
(Address) New City Hospital.15 Filed AY 15 1920 Robert F. [unclear] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 192017 I HEREBY CERTIFY, That I attended deceased from March 29, 1920, to May 14, 1920, that I last saw him alive on May 14, 1920, and that death occurred, on the date stated above, at 9:25 A. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia; Cerebral Thrombosis;

(duration) yrs. mos. ds.

CONTRIBUTORY Broncho-Pneumonia
(Secondary) (duration) yrs. mos. ds.18 Where was disease contracted City
If not at place of death?Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? no special test(Signed) J. P. [unclear], M. D.May 14 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cath Laura Ben May 17 1920

20 UNDERTAKER ADDRESS

Joe J. [unclear] 156 N. [unclear]

TION is very important. See instructions on back of certificates.

D43178

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 17

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2228 Ewing St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wallace Harris

(a) RESIDENCE, NO. 2228 Ewing St. WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 1

mos. 1

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 11-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

10 NAME OF FATHER Bernard Moore

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md (State or country)

12 MAIDEN NAME OF MOTHER Ella Harris

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md (State or country)

14

Informant (Address)

Ella Harris 2228 Ewing St

MAY 15 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1920

17

I HEREBY CERTIFY, That I attended deceased from May 12, 1920, to May 12, 1920, that I last saw him alive on May 12, 1920, and that death occurred, on the date stated above, at 2:40 a.m.

The CAUSE OF DEATH* was as follows:

Secondary hemorrhage following operation (over)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

2228 Ewing St

Did an operation precede death?

Yes Date of May 12-20

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

Wm. R. Johnson M. D.

13. 20 (Address) 3926 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt Auburn

DATE OF BURIAL

May 15 1920

20 UNDERTAKER

Edward Ringgold

ADDRESS

1463 Harry

043179

140053

HEALTH DEPARTMENT—CITY OF BALTIMORE

043179

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST.: *17th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Erlynn Bryant

(a) RESIDENCE. No. *527 N. Park St.* ST.: *Baltimore Md.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *Life* mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April 27, 1918*

7 AGE

Years *2*

Months

Days *16*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child - odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md.* (State or country)

10 NAME OF FATHER

Luther Bryant

11 BIRTHPLACE OF FATHER (city or town) (State or country)

North Carolina

12 MAIDEN NAME OF MOTHER

Lucy Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

J. H. B. Records

15

Filed

Robert P. Harrison,

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 13* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from *April 6*, 19 *20*, to *May 13*, 19 *20*, that I last saw her alive on *May 13*, 19 *20*, and that death occurred, on the date stated above, at *2 a* m.

The CAUSE OF DEATH* was as follows:

miliary tuberculosis

CONTRIBUTORY (Secondary)

(duration)

not known

(duration)

Hereditary syphilis

18 Where was disease contracted if not at place of death?

PTS home

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical

(Signed)

W. H. H. M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Not Auburn

DATE OF BURIAL

May 16 1920

20 UNDERTAKER

Edward Ringgold

ADDRESS

1463 Bay

tion is very important. See instructions on back of certificates.

MAY 15 1920

D43180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43180

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bay View Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.

ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elizabeth Parker

(a) RESIDENCE. No.

13674. Stricker

ST.

WARD. 8

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female Black

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1894

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

26.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Do.

12 MAIDEN NAME OF MOTHER

Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Do.

14

Informant (Address)

Bay View Hospital Baltimore, Md.

15

Filed

19

Registrar

AY 15 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 11, 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 2, 1920, to May 11, 1920

that I last saw him alive on May 10, 1920

and that death occurred, on the date stated above, at 10:10 P.

The CAUSE OF DEATH* was as follows:

Acute Tuberculous Pneumonia

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Miliary tuberculosis

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? Yes No Date of May 6.

Was there an autopsy? Yes No

What test confirmed diagnosis? Phys. Exam & X-Ray

(Signed) N. Goldsmith M. D.

5/13/20 Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Annapolis Md

May 15 1920

20 UNDERTAKER

ADDRESS

Edward Ringgold

1432 Carey

TION is very important. See instructions on back of certificates.

D43181

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43181

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Singer & Hummer Ave 27*ST.: *27* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Godfrey Kerner*(Residence in Baltimore: No. *Denmore Hall -*St. *Unknown* yrs. *Unknown* mos. *Unknown* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

*White*5-SINGLE, *Widowed*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

*73*yrs. *Unknown* mos. *Unknown* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *B-1 Keeper*(b) General nature of industry, business, or establishment in which employed (or employer) *108*9-BIRTHPLACE,
(State or Country),*Germany*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. H. Harris*(Address) *2101 Resbury St*

15-

MAY 15 1920

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*May**14**1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 1**1920**to May 12**1920*that I saw him alive on *May 12**1920*and that death occurred, on the date stated above, at *1 PM*

The CAUSE OF DEATH* was as follows:

Angina Pectoris(Duration) *10*yrs. *10*mos. *10* ds.CONTRIBUTORY
(Secondary)*Arterial Sclerosis*(Duration) *3*yrs. *3*mos. *3* ds.(Signed) *Wm J. Love*

M. D.

May 14, 1920(Address) *836 W. North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*San Sinae Cem**5/16, 1920*

20-UNDERTAKER

ADDRESS

*David Soudbeind**110 W. 8th Royal Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43182

CERTIFICATE OF DEATH.

51 ✓ D43182
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 1/2 Calhoun ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline F. Becker(a) RESIDENCE. No. 502 1/2 Calhoun ST., 19 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of -6 DATE OF BIRTH (month, day, and year) Aug. 30, 18817 AGE Years 38 Months 8 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher(b) General nature of industry, business, or establishment in which employed (or employer) Eastern High School

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)10 NAME OF FATHER Charles R. Becker11 BIRTHPLACE OF FATHER (city or town) Balto. Md (State or country)12 MAIDEN NAME OF MOTHER Mary A. Middleton13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)14 Informant Chas R. Becker (Address) 502 1/2 Calhoun St15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 192017 I HEREBY CERTIFY, That I attended deceased from May 6, 1920, to May 14, 1920, that I last saw her alive on May 14, 1920, and that death occurred, on the date stated above, at 8:30 P. M. The CAUSE OF DEATH* was as follows:Exophthalmic Goiter(duration) 8 yrs. - mos. - ds.CONTRIBUTORY Cardiac Dilatation (Secondary)(duration) - yrs. - mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of -Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George D. Hoff, M. D.5/15/1920 (Address) 2020 1/2 Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

20 UNDERTAKER

Geo W Little

DATE OF BURIAL

May 17 1920

ADDRESS

531 A Fremont

TION is very important. See instructions on back of certificates.

D43183

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43183

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 N. Pulaski ST.; 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Oliver H. Keith

(Residence in Baltimore: No. 520 N. Pulaski St.; 65 yrs., 10 mos., 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-STATUS:
MARRIED, *Married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

July 6, 1854
(Month) (Day) (Year)

7-AGE,

65 yrs., 10 mos., 8 ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Retired B+O
Conductor 9739-BIRTHPLACE,
(State or Country).

Howard Co. Md.

10-NAME OF FATHER,

Horatio Keith

11-BIRTHPLACE OF FATHER
(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Don't Know

13-BIRTHPLACE OF MOTHER
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Horatio Keith Jr.*(Address) *520 N. Pulaski St.*

15-

Filed MAY 15 1920
Robert P. Harrison,
191.....
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1920, to May 14 1920, that I saw him alive on May 14 1920, and that death occurred, on the date stated above, at 12:15 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis & Mitral Stenosis

(Duration).....yrs. 8 mos.ds.

CONTRIBUTORY.....
(Secondary) Rheumatism

(Duration).....yrs. 18 mos.ds.

(Signed) *Benj. F. Phillips* M. D.May 15, 1920 (Address) *1929 N. Davidson St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.mos.ds. In the State.....yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill

DATE OF BURIAL,

May 17 1920

20-UNDERTAKER

Geo W Little

ADDRESS

5318 Fremont Ave

D43184

HEALTH DEPARTMENT--CITY OF BALTIMORE

D43181

CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1516 John St

ST. 14 WARD)

2-FULL NAME John P. Perkinson Jr

(Residence in Baltimore: No. 1516 John

St.: yrs. mos. 2 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

white

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6-DATE OF BIRTH

May 13, 1920
(Month) (Day) (Year)

7-AGE

yrs. mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE
(State or country)

Baltimore

10-NAME OF FATHER

John P. Perkinson

PARENTS

11-BIRTHPLACE OF FATHER
(State or country)

Baltimore

12-MAIDEN NAME OF MOTHER

Mary E. Minner

13-BIRTHPLACE OF MOTHER
(State or country)

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mary E. Perkinson

(Address) 1516 John St.

15

Robert P. Harrison,

Burial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 15, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 13, 1920, to May 14, 1920

that I saw him alive on May 14, 1920.

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Defective development of heart - cleft pulat

(Duration) yrs. mos. 1 ds

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) B. B. Browne M. D.

May 15, 1920 (Address) 510 Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Peters

DATE OF BURIAL

May 15, 1920

20-UNDERTAKER

Martin Fahy, Son 1827 W. North

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female*
 4-COLOR OR RACE, *White*
 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*
 6-DATE OF BIRTH, *April 16*, 18*88*
 (Month) (Day) (Year)

7-AGE, *32* yrs. — mos. — ds.
 If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 15, 19*20*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Oct 20* 19*20*, to *May 15* 19*20*, that I saw h or alive on *May 14* 19*20*, and that death occurred, on the date stated above, at *9 a.* m. The CAUSE OF DEATH* was as follows:

Ac Cardiac Dehension
 (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

J. E. D. Jacobson
 May 15, 1920 (Address) *1353 W. North*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Columbia City Md *May 17*, 19*20*

20-UNDERTAKER

ADDRESS

W. M. Galt *Royal Oak*

MAY 15 1920

RECEIVED

Watchman

D43186

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bay View Hospital

CITY OF BALTIMORE: (No.

ST. 14

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sophia Holton

(a) RESIDENCE. NO.

210 Division

(Usual place of abode)

ST. 21st WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos.

ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1835

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

85.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Do.

12 MAIDEN NAME OF MOTHER

Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Do.

14

Informant (Address)

Bay View Hospital Baltimore, Md.

15

Filed

MAY 16 1920

ROBERT H. ERATTEL Registrar

Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 14, 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 8, 1920, to May 14, 1920,

that I last saw her alive on May 13, 1920,

and that death occurred, on the date stated above, at 12:00 a.m.

The CAUSE OF DEATH* was as follows:

Bacterial Pneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY

Acute Dementia +

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

Phys. Exam.

(Signed)

H. G. Edwards M. D.

5/14/20 Address)

Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

May 17 1920

20 UNDERTAKER

ADDRESS

Joseph A. Farrell

2312 Division

TION is very important. See instructions on back of certificates.

D43187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1946 W. Linnvale ST.; 16 WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. 1946 W. Linnvale St.; 65 yrs., — mos., — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Widowed

6-DATE OF BIRTH,

June 30th, 1836
(Month) (Day) (Year)

7-AGE,

83 yrs., 10 mos., 15 ds.IF LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....Retired9-BIRTHPLACE,
(State or Country),Germany10-NAME OF
FATHER,William Hagerer11-BIRTHPLACE
OF FATHER
(State or Country),Germany12-MAIDEN NAME
OF MOTHERUnknown13-BIRTHPLACE
OF MOTHER
(State or Country),Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gudolph Franz(Address) 1946 W. Linnvale St.

15-

MAY 16 1920 ROBERT R. KRAUTER

Filed

191

Baltimore

City

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 15th, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
March 4, 1920, to date of death,
that I saw him alive on May 15th, 1920,
and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Due to a long standing
intermittent dyspepsia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) William L. Davis M. D.May 16, 1920 (Address) 824 N. Fulton*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS-
IENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

Louisa Park Cem.

DATE OF BURIAL,

May 17th, 1920

20-UNDERTAKER

Charles John H. Toulon

ADDRESS

801 W. Fayette St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43188

CERTIFICATE OF DEATH.

D43188

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2859 W. North Ave. St.; 15 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2859 W. North Ave. St.; 50 yrs., 11 mos., 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male.

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

(Month) May (Day) 23, (Year) 1848

7-AGE,

71 yrs., 11 mos., 17 ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Bookkeeper

9-BIRTHPLACE,
(State or Country),

Md.

PARENTS.

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

MAY 16 1920

ROBERT B. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) 5 (Day) 14, (Year) 1920

17- I HEREBY CERTIFY, That I attended deceased from

Oct. 9 1919, to May 5 1920,that I saw him alive on May 13 1920,and that death occurred, on the date stated above, at 5:45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs., 11 mos., 17 ds.CONTRIBUTORY
(Secondary)myocarditis (Duration) 1 yrs., 11 mos., 17 ds.(Signed) A. H. Miller M. D.5/14/20 (Address) 2757 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore May 17, 1920.

20-UNDERTAKER

ADDRESS

William Cook 502 E. North Ave.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D43189

CERTIFICATE OF DEATH.

39

D43189

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1430 Folmer

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A Bryan

(Residence in Baltimore: No. 1430 Folmer St. 10 years in city St. Lifes mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

July 25

(Month)

(Day)

1864 (Year)

7-AGE,

5-5

yrs.

8 mos.

19

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Iron Worker
Gettysburg Pipe Co

9-BIRTHPLACE,

(State or Country).

Baltimore Md

10-NAME OF FATHER,

William A Bryan

11-BIRTHPLACE OF FATHER

(State or Country).

Baltimore Md

12-MAIDEN NAME OF MOTHER

Estina Hubber

13-BIRTHPLACE OF MOTHER

(State or Country).

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAY 16 1920

ROBERT E. RAUTER

Filed

191

Baltimore

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

(Month)

14

(Day)

1920 (Year)

I HEREBY CERTIFY, That I attended deceased from January 1919, to May 14 1920, that I saw him alive on May 14 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Malignant Epithelioma of left side of mouth jaw
Small neck abscess

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs. mos. ds.

(Signed) H. Young Northrop M. D.

May 14, 1920 (Address) 602 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore

DATE OF BURIAL,

May 17, 1920

20-UNDERTAKER

William Cook

ADDRESS

602 E. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24 D43190

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Dorchester Heights* ST. *10th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Blanche E. Steinfacher*(a) RESIDENCE. No. *Dorchester Heights* ST. *10th* WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.How long in U. S., if of foreign birth *Life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct 1918*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Seal room

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt.

10 NAME OF FATHER

George P. Steinfacher

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Bartha Steinfacher

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Geo. P. Steinfacher
Dorchester Heights

15

MAY 16 1920

ROBERT A. LAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 15 1920*

17

I HEREBY CERTIFY, That I attended deceased from *May 14 1920* to *May 15 1920*, that I last saw her alive on *May 15 1920*, and that death occurred, on the date stated above, at *2:45 A.M.*

The CAUSE OF DEATH* was as follows:

Acute Tetanus(duration) yrs. mos. ds. *1*

CONTRIBUTORY

Puncture wound of right foot(duration) yrs. mos. ds. *7*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Lawrence Wheeler*, M. D.19 (Address) *Lakeland, Baltimore*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery May 17 1920

20 UNDERTAKER

ADDRESS

Geo. P. Steinfacher

D43191

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170

D43191

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital.ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Sanders(a) RESIDENCE. No. 701 Lanvale St.

(Usual place of abode)

ST.: 17 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. life

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1851

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.abt. 69

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)10 NAME OF FATHER John Sanders11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.12 MAIDEN NAME OF MOTHER Lizzie Allen13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14

Informant Hospital Records
(Address) New City Hospital.

15

Filed MAY 16 1920 ROBERT E. KRAUTER
Registrar
Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1920

17

I HEREBY CERTIFY, That I attended deceased from
April 21, 1920, to May 15, 1920
that I last saw him alive on May 14, 1920
and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis(duration) yrs. 4 mos. ds.CONTRIBUTORY
(Secondary)Uremia(duration) yrs. 7 mos. ds.18 Where was disease contracted
if not at place of death?UnknownDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

Blood & Urine

(Signed)

J. J. Kessel

, M. D.

May 15 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Int. Carmel

DATE OF BURIAL

May 18 1920

20 UNDERTAKER

William Cook

ADDRESS

502 E. North

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43192

D43192

CERTIFICATE OF DEATH.

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1224 N. Gilman St. 16 WARD)

FULL NAME

Mary Jane Gordon

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1224 N. Gilman St.

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Filed

101

ROBERT B. KEAUTER

BURIAL

C/o Buel C. Gordon

via P.R.R.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) had that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed) J. P. D. Harrison M. D.

May 14, 1920 (Address) 2802 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Harrisville Md. May 18, 1920

Crown Cooks

506 North

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

George E Alexander

(a) RESIDENCE. NO.

Shawnee Oklahoma

WARD.

Shawnee Oklahoma

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Unknown

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

man

4 COLOR OR RACE

*white*5 ~~Single~~ Married, Widowed, or Divorced (write the word)*Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 14-1918

7 AGE

2

Years

1

Months

Days

1

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Shawnee Oklahoma

10 NAME OF FATHER

George Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Arkansas

12 MAIDEN NAME OF MOTHER

Jora Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Texas

14

Informant (Address)

John Records

15

Filed

*MAY 16 1920**ROBERT E. HALL*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 15 1920

17

I HEREBY CERTIFY, That I attended deceased from *May 12*, 1920, to *May 16*, 1920, that I last saw him alive on *May 16*, 1920, and that death occurred, on the date stated above, at *5:55 P. m.*

The CAUSE OF DEATH* was as follows:

Congenital malformation of the brain(duration) *since birth* yrs. mos. ds.

CONTRIBUTORY (Secondary)

none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Birth

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical diagnosis

(Signed)

len. J. P.

M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Shawnee Oklahoma**May 14 1920*

20 UNDERTAKER

ADDRESS

Wm. C. Black 927 N. Broadway

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43195

CERTIFICATE OF DEATH.

151
D43195
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 Bradley ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 811 Bradley St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Male</u>	4-COLOR OR RACE, <u>Caucas</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <u>Single</u>
6-DATE OF BIRTH, <u>May</u> <u>13</u> , <u>1920</u> (Month) (Day) (Year)		
7-AGE, yrs. mos. ds. <u>3</u>		If LESS than 1 day, hrs. or min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer)..... <u>None</u>		
9-BIRTHPLACE, (State or Country), <u>Baltimore Md.</u>		

PARENTS.	10-NAME OF FATHER, <u>Raymond Nelson</u>
	11-BIRTHPLACE OF FATHER (State or Country), <u>Baltimore Md.</u>
	12-MAIDEN NAME OF MOTHER <u>Bessie Grant</u>
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Baltimore Md.</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond Nelson
(Address) 811 Bradley St.

15-

Filed MAY 16 1920 191. ROBERT B. EHAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 16, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
May 13, 1920, to May 16, 1920,
that I saw him dead on May 16, 1920,
and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY
(Secondary)(Signed) R. C. Deluz M. D.
May 16, 1920 (Address) Unsubscribed

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Ambrose Church

DATE OF BURIAL,

May 16, 1920

20-UNDERTAKER

Daniel Easton

ADDRESS

Green a ar

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43196

D43196

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (Municipal Tuberculosis Hospital) 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Young

(a) RESIDENCE. No. 732 George St.

ST. WARD.

(Usual place of abode)

Unknown

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
47				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)
(State or country)

Maryland

10 NAME OF FATHER

Edward Young

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Elizabeth Wright

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant. Hospital Records
(Address)

15

Filed MAY 16 1920 ROBERT E. ELLIOTT

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13th, 1920

17 I HEREBY CERTIFY, That I attended deceased from April 9th, 1920, to May 13th, 1920, that I last saw him alive on May 12th, 1920, and that death occurred, on the date stated above, at 7.35 a. m. The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis T.B. in sputum & X-Ray

(Signed)

George R. Wilkman, M. D.
5-13-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Peter B. B. B.

May 16 1920

20 UNDERTAKER

ADDRESS 916

Daniel Easton

Bum as

TION is very important. See instructions on back of certificates.

D43197

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43197

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 Little Pine St ST.: 17 WARD)REGISTERED NO. _____
(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)2-FULL NAME Eva Washington(a) RESIDENCE, No. 908 Little Pine St ST. _____ WARD. _____

(Usual place of abode)

(If nonresident give city and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX _____ 4 COLOR OR RACE _____ 5 Single, Married, Widowed,
or Divorced (write the word)Female Colored Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18927 AGE Years _____ Months _____ Days _____ If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work Housework(b) General nature of industry,
business, or establishment in
which employed (or employer) 037

(c) Name of employer _____

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md10 NAME OF FATHER John Grant11 BIRTHPLACE OF FATHER (city or town)
(State or country) _____12 NAME OF MOTHER Johnnie Grant13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.14 Information (Address) Johnnie Grant
908 Little Pine St15 Filed MAY 16 1920 ROBERT E. FRANTZ Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 192017 I HEREBY CERTIFY, That I attended deceased from
March 7, 1920, to May 12, 1920,
that I last saw her alive on May 12, 1920,
and that death occurred, on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs
Haemorrhage of Lungs(duration) yrs. 4 mos. ds.CONTRIBUTORY Haemorrhage of Lungs
(Secondary) (duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death? _____Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) D. G. Kennard M. D.5-12-1920 (Address) 708 Euseb St*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

My Auburn Ave May 16 192020 UNDERTAKER Daniel Eorton 716

HEALTH DEPARTMENT--CITY OF BALTIMORE

D43198

D43198

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 220 N. Gilmore St. ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Katherine C. Marriott(Residence in Baltimore: No. 220 N. Gilmore St. St. 19 yrs. 58 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE Widow
MARRIED
WIDOWED
OR DIVORCED
(Write the word)6-DATE OF BIRTH May 14 1920
(Month) (Day) (Year)7-AGE 80 yrs. 10 mos. 15 ds. or min.?
If LESS than 1 day, hrs., min.?8-OCCUPATION
(a) Trade, profession or particular kind of work house wife
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE
(State or country) Calvert Co10-NAME OF FATHER Charles Weems11-BIRTHPLACE OF FATHER
(State or country) Calvert. Co.12-MAIDEN NAME OF MOTHER Sarah Norman13-BIRTHPLACE OF MOTHER
(State or country) Anne Arundle Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. B. Richardson(Address) 220 N. Gilmore St.15- MAY 16 1920 ROBERT B. ELAUGHTERFiled 191 Serial 1 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 5, 1920, to, May 14, 1920,that I saw him alive on May 14, 1920,and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.(Duration) yrs. mos. 3 ds.Contributory
(SECONDARY)Capillary Bronchitis(Duration) yrs. mos. 10 ds.(Signed) M. B. Berman and Lovel M. D.May 15, 1920 [Address] 626 N. Gilmore St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

May 17, 1920

20-UNDERTAKER

Wilbur W. Shivers

ADDRESS

118 Edmondson Ave

state CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43199

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

Monument St

ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Annie Amrein

(Residence in Baltimore: No.

250 S. Bouldin St

St.; 12 yrs., 3 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Jan 21st

1907

(Month)

(Day)

(Year)

7-AGE,

12 yrs., 3 mos. 23 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Child
at school

9-BIRTHPLACE,

(State or Country),

Balto. Md.

10-NAME OF FATHER,

John Amrein

11-BIRTHPLACE

OF FATHER
(State or Country),

Balto. Md.

12-MAIDEN NAME
OF MOTHER

Carrie Kondran

13-BIRTHPLACE

OF MOTHER
(State or Country),

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Concanon (Mother)

(Address) 250 S. Bouldin

15-

Filed

MAY 16 1920

ROBERT R. ERAUTER

BALTIMORE REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

14th, 1920

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 13, 1920, to May 14, 1920,

that I saw her alive on May 14, 1920,

and that death occurred, on the date stated above, at 9⁰⁰ a.m.

The CAUSE OF DEATH* was as follows:

Acute Dystrophia - Left

Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Charles J. Lany, M. D.

5-14-24, 1921 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

1006 Redcross

DATE OF BURIAL,

May 17, 1920

20-UNDERTAKER

Lilly & Zeiler

ADDRESS

403 S. Wolfe St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43200

CERTIFICATE OF DEATH.

REGISTERED NO. C

D43200

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 N. Duncan ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1805 N. Duncan St.;yrs., 1 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) Single

6-DATE OF BIRTH,

March 26, 1920
(Month) (Day) (Year)

7-AGE,

.....yrs. 1 mos. 19 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

None9-BIRTHPLACE,
(State or Country),Baltimore Md

10-NAME OF FATHER,

August Severin11-BIRTHPLACE OF FATHER
(State or Country),Baltimore Md

12-MAIDEN NAME OF MOTHER

Annie E Smith13-BIRTHPLACE OF MOTHER
(State or Country),Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August Severin(Address) 1805 N. Duncan

15-

MAY 16 1920

ROBERT H KRAUTER

Filed.....

191.....

BUTLER FARMER & CO. Registrars

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 14, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 10 1920, to May 14, 1920, that I saw him alive on May 14, 1920, and that death occurred, on the date stated above, at 11:19 p. m.
The CAUSE OF DEATH* was as follows:Bronchial Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Edwin B. Fenty M. D.May 15, 1920. (Address) 1222 N. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Louisa Park

DATE OF BURIAL,

May 17 1920

20-UNDERTAKER

Henry Lutz

ADDRESS

1007 N. Bond

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43201

CERTIFICATE OF DEATH.

91 D43201

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *932 N. Chester*ST.: *7*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Winifred Raborg*(a) RESIDENCE. NO. *932 N. Chester*

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*single*6 DATE OF BIRTH (month, day, and year) *March 17 = 1918*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*2**1**28*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

house

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

unknown

12 MAIDEN NAME OF MOTHER

Mrs. Raborg

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Mrs. Raborg 932 N. Chester St

15

Filed

*MAY 16 1920**ROBERT A. KAUTER*

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 15* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from *May 14*, 19*20*, to *May 15*, 19*20*, that I last saw h. *alive* on *May 15*, 19*20*, and that death occurred, on the date stated above, at *3:15 A* m.

The CAUSE OF DEATH* was as follows:

Bronchio pneumonia(duration) yrs. mos. ds. *2*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *1*

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Edward J. Cook*, M. D.*5/15, 1920* (Address) *413 N. Washington St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St Patrick Cemetery**May 17 1920*

20 UNDERTAKER

ADDRESS

*Henry Lutz**1007 Bond St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D43202

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43202

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2501 Penna. Ave. ST.; 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pirualo N. Kirasotis(a) RESIDENCE. No. 2501 Penna. Ave. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofGus Kirasotis6 DATE OF BIRTH (month, day, and year) Feb 14 - 18937 AGE Years 27 Months 3 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Greece

10 NAME OF FATHER

Nicholas Sifto

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Greece

12 MAIDEN NAME OF MOTHER

Samatia Krasas

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Greece

14

Informant
(Address)Gus Kirasotis
2501 Penna. av.

15

Signed

MAY 16 1920

ROBERT A. KLAUTER

Registrar

Burial Permit (City)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 10, 1920, to May 14, 1920,that I last saw her alive on May 14, 1920,and that death occurred, on the date stated above, at 3:15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) yrs. 6 mos. — ds.CONTRIBUTORY
(Secondary)(duration) yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Edward Novak

M. D.

, 19 (Address) 821 N. Paul PK av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cent May 17

20 UNDERTAKER

ADDRESS

Isiah Sykes 1600 N. Martha

CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43201

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1405 S. Clinton*)

2-FULL NAME

(a) RESIDENCE. No. *1405 S. Clinton*
(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

45 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST.: *26*

WARD)

ST.

WARD.

(If nonresident give city or town and State)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 14* 19 *20*17 I HEREBY CERTIFY, That I attended deceased from *July 1st* 19 *19* to *May 14* 19 *20*,
that I last saw him alive on *May 14* 19 *20*,
and that death occurred, on the date stated above, at *8:45 P.* m.
The CAUSE OF DEATH* was as follows:*Arterio Sclerosis*CONTRIBUTORY *Chronic Eukriti*
(Secondary) (duration) *2* yrs. mos. ds.18 Where was disease contracted *Self.*
If not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

5/16/20

Address)

1839 S. Ellwood St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt Carmel Cemetery

20 UNDERTAKER

Girkler + Girkler

DATE OF BURIAL

May 17 19 *20*

ADDRESS

1739 E. Eager St.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*White*5 Single, Married, Widowed,
or Divorced (write the word)*Married*5a If married, widowed, or divorced
HUSBAND of*Elizabeth Vandermaast*
Aug 17-1855

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.

or min.

*64**8**27*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Cigar-maker*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Germany.*

10 NAME OF FATHER

*Adolph P. Vandermaast*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Germany*

12 MAIDEN NAME OF MOTHER

*Not known*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Not known*

14

Informant
(Address)*Elizabeth Vandermaast*
1405 S. Clinton St.

15

*MAY 16 1920*ROBERT E. LAUTER
Registrar

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43205

CERTIFICATE OF DEATH.

REGISTERED NO.

D43205

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1544 N. Fulton Ave. ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Carmine(a) RESIDENCE. No. Ridgely, Md. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 35 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) Mary Francis Carmine6 DATE OF BIRTH (month, day, and year) Mar 12, 18407 AGE Years 80 Months 2 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter & Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Caroline County
(State or country) Maryland10 NAME OF FATHER Thomas Carmine11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)12 MAIDEN NAME OF MOTHER Martha Chilcutt13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)14 Informant Wm Carmine
(Address) St Helena, Md.15 MAY 16 1920 ROBERT A. KANTER
Registrar

Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 192017 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1920, to May 14, 1920 that I last saw him alive on May 14, 1920 and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Paralysis.(duration) yrs. mos. 15 ds.CONTRIBUTORY Angina Pectoris & Arterio-
(Secondary) Sclerosis (duration) yrs. 7 mos. ds.18 Where was disease contracted Ridgely, Md.
If not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Paralysis.(Signed) Wm Carmine M. D.19 (Address) St Helena, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Preston Md May 17 1920

20 UNDERTAKER ADDRESS

JOHN F. DENNY 715 LIGHT ST.

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43206

CERTIFICATE OF DEATH.

152 D43206

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, 13 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed MAY 16 1920

ROBERT E. LAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

May 14, 1920, to May 15, 1920,

that I last saw him alive on May 15, 1920,

and that death occurred, on the date stated above, at 7:15 a.m.

The CAUSE OF DEATH* was as follows:

- Ulcerated 7 Rungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43207

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Union Protestant Infirmary

REGISTERED NO. C

D43207

CITY OF BALTIMORE: (No.

1514 Division

St.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

John Traub

(Residence in Baltimore: No.

219 N. Bond

St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

widowed

6-DATE OF BIRTH,

July

1871

7-AGE,

48 yrs., 10 mos., ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Stenographer

9-BIRTHPLACE,
(State or Country),

Russia

PARENTS.

10-NAME OF FATHER,

Ethan Traub

11-BIRTHPLACE OF FATHER
(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. Lewis

(Address)

1411 E. Baltimore St.

15-

MAY 16 1920

ROBERT E. KAUFER

Filed..... 191

Baltimore City Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 14th

(Month)

(Day)

1920

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 16th 1920, to May 14th 1920,that I saw him alive on May 14th 1920,

and that death occurred, on the date stated above, at 2:40 P.m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease; auricular fibrillation; chronic interstitial nephritis.

(Duration) 12 yrs., mos., ds.

CONTRIBUTORY

Broncho-pneumonia, with

(Secondary)

pulmonary edema (Duration) yrs., mos., ds.

(Signed)

J. M. Williams, M. D.

May 14th, 1920. (Address) Union Protestant Infirmary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

at home

Former or usual residence

219 N. Bond St., Baltimore, Md.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew Washington Rd

May 16, 1920

20-UNDERTAKER,

ADDRESS

Jack Lewis

1411 E. Baltimore St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43208

CERTIFICATE OF DEATH.

145
REGISTERED NO. C

D43208

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.: yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15

MAY 16 1920

ROBERT H. KAUFER

Filed

191

Burial Permit Required

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 12 1920, to May 15 1920,

that I saw her alive on May 15 1920,

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Congenital Ichthyosis

(Duration) yrs. mos. da.

CONTRIBUTORY.
(Secondary)

(Duration) yrs. mos. da.

(Signed) Harry Goldmann M. D.

5/15/20 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew Mt. Cemetery

May 16 1920

20-UNDERTAKER

ADDRESS

Jack Lewis, 1411 E. Balto

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43209

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F

4-COLOR OR RACE,

W

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

10 17, 1916
(Month) (Day) (Year)

7-AGE,

4 yrs. 7 mos. ds.

If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, business, or establishment in which
employed (or employer)

Child

9-BIRTHPLACE,
(State or Country),

Dougherty W Va

10-NAME OF
FATHER,

Antonio Farcella

11-BIRTHPLACE
OF FATHER
(State or Country),

Italy

12-MAIDEN NAME
OF MOTHER

Giuseppina Antonelli

13-BIRTHPLACE
OF MOTHER
(State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antonio Farcella

(Address) 407 S 4th St

15-MAY 16 1920 ROBERT H. KRAUTER

Filed..... 191. Burial Permit Class.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5

15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

5/14/20 191, to 5/15/20 191,

that I saw her alive on 5/15/20 191,

and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Intoxication

CONTRIBUTORY.
(Secondary)

(Duration) yrs. mos. ds.

Epileptic Meningitis

(Signed)

(Duration) yrs. mos. ds.

J. H. Carroll M. D.

(Address) 633 S 5th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

Brooklyn N Y

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Stanislaus Cu

May 16, 1920

20-UNDERTAKER

ADDRESS

J. Hervey & Co

2008 Belair

important. See instructions on back of certificate.

D43210

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43210

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Wt Stone Retreat* ST. *28* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Peter J. Duruis(a) RESIDENCE. NO. *Phila Pa.* ST. *Phila Pa.* WARD. *Phila Pa.*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

24

ds.

How long in U. S., if of foreign birth?

50

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

None

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

78

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Religious - 065

(b) General nature of industry, business, or establishment in which employed (or employer)

Religious Work.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Holland

10 NAME OF FATHER

Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Don't Know

12 MAIDEN NAME OF MOTHER

Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Don't Know

14

Informant (Address)

Records of Wt Stone Retreat Wt Stone Retreat

15

MAY 16 1920

ROBERT R. EBAUTER

Registrar

Burial 11:11 O'clock

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 16 19*20*

17

HEREBY CERTIFY, That I attended deceased from

Apr 23, 1920, to *May 16*, 1920,that I last saw him alive on *May 16*, 1920,and that death occurred, on the date stated above, at *10:30* p. m.

The CAUSE OF DEATH* was as follows:

*Paralysis - (Bulbar)**less*(duration) *1* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary)

Acute Pneumonia -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*Phila Pa*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Frank J. Flannery*, M. D., 19 (Address) *Wt Stone Retreat*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Private - N. J. May 16/20

20 UNDERTAKER

STEWART & MOWEN COMPANY

(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D4321P

CERTIFICATE OF DEATH.

D4321P

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2925 St Paul ST.; 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lillian Lenox Barnes

(a) RESIDENCE. No.

2925 St Paul

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mr Barnes

6 DATE OF BIRTH (month, day, and year)

April 9-1867

7 AGE

53

Years

Months

1

Days

5

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Mr Peat

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Mary V. Peterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Mr Barnes
2925 St Paul St

15

MAY 17 1920ROBERT A. FRANTZ
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 14 1920

17

I HEREBY CERTIFY, That I attended deceased from

1914, to May 14, 1920,that I last saw h. e. alive on May 14, 1920,and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus
Chronic Intestinal Hepatitis(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Uræmic Coma(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy?

What test confirmed diagnosis? uric tests(Signed) Harvey B. Beck M. D.19 (Address) 30 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lorraine ParkMay 17 1920

20 UNDERTAKER

ADDRESS

H. C. Wiedefeld 914 Green St

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43212

CERTIFICATE OF DEATH.

REGISTERED NO. C

D43212

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

716 1/2 W. Franklin St.

WARD) 4

2-FULL NAME

Katie Taylor

(Residence in Baltimore: No.

716 1/2 W. Franklin

St.: 40 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH.

Aug 1920

1872

(Month)

(Day)

(Year)

7-AGE

48

IF LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country).

Goochland Co Va

10-NAME OF FATHER.

Wm. M. M. M.

11-BIRTHPLACE OF FATHER (State or Country).

Virginia

12-MAIDEN NAME OF MOTHER

Wm. M. M. M.

13-BIRTHPLACE OF MOTHER (State or Country).

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Edward Taylor

(Address)

716 1/2 W. Franklin

15-

MAY 17 1920

ROBERT B. KRAUTER

SPECIAL INCH. 100.1

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 13

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 22 1920, to May 13 1920, that I saw her alive on May 12 1920, and that death occurred, on the date stated above, at 1.20 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 7 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 3 yrs. 3 mos. ds.

(Signed) H. P. Hughes M. D.

5/13, 1920 (Address) 724 W. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

St. Urbanus Church

DATE OF BURIAL

May 17 1920

20-UNDERTAKER

James H. H. H.

ADDRESS

578 W. Biddle

important. See instructions on back of certificate.

D43213

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43213

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1559 Woodyear St.

ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Curtis

(a) RESIDENCE. No. 1559 Woodyear St.
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? 41 yrs. 3 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female Negro Widowed

5a If married, widowed, or divorced

HUSBAND of

XXX XXXX Robert Curtis

6 DATE OF BIRTH (month, day, and year) Dec. 15. 1879

7 AGE Years Months Days If LESS than 1 day. hrs. or min.
41 3 28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Worked at home

(c) Name of employer Herself

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

10 NAME OF FATHER Peter Howard

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Racchel Snowden

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.14 Informant Mary Allen (Daughter)
(Address) 1559 Woodyear St.

15 Filed MAY 17 1920 ROBERT R. KRAUTER Registrar

Burial Permit 0181

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/13/20. 19

17 I HEREBY CERTIFY, That I attended deceased from May 4th. 1920, to May 13th 1920

that I last saw her alive on May 13, 1920

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Acct. Peritonitis due to perforation of Gastric ulcer.

(duration) yrs. mos. ds.

CONTRIBUTORY Acct. Broncho Pneumonia
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Walter J. Jackson, M. D.

19 (Address) 1618 N. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43214

CERTIFICATE OF DEATH.

D43214

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Md. General Hospital

ST.:

WARD) 6

2-FULL NAME

Sadie Reckroth

(a) RESIDENCE. NO.

2800 E. Baltimore

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed,
or Divorced (write the word)

married

5a If married, widowed, divorced,
HUSBAND of
(or) WIFE of

Sadie Reckroth

6 DATE OF BIRTH (month, day, and year)

May 18 1856

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

None 037

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

James H. Parker

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary J. Williams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Baltimore

14

Informant
(Address)Margaret Corner
816 E. North Ave

15

FILE

MAY 17 1920

ROBERT E. KRAUTER

Registrar

Burial Permit 0101

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

ST.:

WARD)

ST.:

WARD.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1920

17

I HEREBY CERTIFY, That I attended deceased from
May 10 1920, to May 15 1920,

that I last saw him alive on May 15 1920,

and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis &
angina pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Chronic myocarditis &
atherosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

2800 E. Balto St.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical examination

(Signed) H. E. Wright M. D.

5/15, 1920 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

May 17 1920

20 UNDERTAKER

Robert Turner

ADDRESS

1442 4th Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43215

CERTIFICATE OF DEATH.

79 D43215

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Homewood Apts* ST.: *12* WARD)2-FULL NAME *Edgar Forrester Horner*(a) RESIDENCE. NO. *Homewood Apts* ST. *12* WARD. *(Resident)*

(Usual place of abode)

Length of residence in city or town where death occurred *58* yrs. *4* mos. *12* ds. How long in U. S., if of foreign birth? *58* yrs. *4* mos. *12* ds.REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *(none)*6 DATE OF BIRTH (month, day, and year) *January-3-1862*7 AGE Years *58* Months *4* Days *12* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*10 NAME OF FATHER *John Q. Horner*11 BIRTHPLACE OF FATHER (city or town) *Finksburg* (State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Catherine Forrester*13 BIRTHPLACE OF MOTHER (city or town) *Eldersburg* (State or country) *Maryland*14 Informant *Mr. Edward D. Crook (Sister)* (Address) *Homewood Apts.*15 *MAY 17 1920* *ROBERT F. FRATER* Registrar *Barial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May-15 1920*17 I HEREBY CERTIFY, That I attended deceased from *April*, 19*20*, to *May 13*, 19*20*, that I last saw him alive on *May 11*, 19*20*, and that death occurred, on the date stated above, at *8:30 a* m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease(duration) *5* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. Fred Adams*, M. D., 19 (Address) *1314 N Charles St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Louisa Park Cemetery May 17 1920*20 UNDERTAKER *STEWART & MOWEN COMPANY* (WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1009 Bkn.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43216

CERTIFICATE OF DEATH.

D43216

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 Park Ave ST. 11 WARD)

2-FULL NAME Robert Hickley Jenkins

(a) RESIDENCE. NO. 607 Park Ave ST. 11 WARD.

(Usual place of abode) Length of residence in city or town where death occurred 72 yrs. 8 mos. 9 ds. How long in U. S., if of foreign birth? 72 yrs. 8 mos. 9 ds.

REGISTERED NO. 170
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(Resident)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (none)

6 DATE OF BIRTH (month, day, and year) Sept-6-1847

7 AGE Years 72 Months 8 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Alfred Jenkins

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Hickley

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr Alfred J. Shriver - (nephew)
(Address) 801 N. Charles St.

15 MAY 17 1920 ROBERT B. FRASTER
Serial 1011 City

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH (month, day, and year) 5/15/ 1920

17 I HEREBY CERTIFY, That I attended deceased from Ap. 1st, 1920, to May 15, 1920, that I last saw him alive on May 14, 1920, and that death occurred, on the date stated above, at 12⁰⁰ a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bulbourethral Neoplasia
+ Hypertrophy of Prostate
Gland.

(duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. 0 mos. 2 ds.

18 Where was disease contracted at Place of Death
If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. T. O'Brien M. D.

5/16 1920 (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Charles College - Calmarville DATE OF BURIAL May 18 1920

20 UNDERTAKER STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

D43217

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43217

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1434 Montpelier ST. 9 WARD)

2-FULL NAME

(a) RESIDENCE. No. 1434 Montpelier ST. 9 WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Unversagt

6 DATE OF BIRTH (month, day, and year) Mar 6, 1859

7 AGE Years 61 Months 2 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

MAY 17 1920

ROBERT E. YEATMAN

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1920

17

I HEREBY CERTIFY, That I attended deceased from much, 1920, to May 15, 1920, that I last saw her alive on May 13, 1920, and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

CONTRIBUTORY (Secondary)

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Microscope(Signed) Dr. J. J. Keeney, M. D. 5/16/20 (Address) 2700 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43218

CERTIFICATE OF DEATH.

D43218

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2039 Gough St ST. 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles Rusteberg

(a) RESIDENCE. NO.

2039 Gough St

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (use the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Katherine Rusteberg

6 DATE OF BIRTH (month, day, and year)

Oct 17th 1839

7 AGE Years 80 Months 6 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

At home

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Ludwig Rusteberg

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mary Rusteberg 2039 Gough St

15

Filed

MAY 17 1920 ROBERT B. KRAUTER Registrar

Barial Permit 0147

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23 1919, to May 14 1920,

that I last saw him alive on May 14 1920, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical symptoms

(Signed) Geo. Heller M. D.

5.15.20 (Address) 1937 Gough St

*State the Disease Causing Death or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Carmel Cem

May 17 1920

20 UNDERTAKER

ADDRESS

J. Herwig & Co

2008 Belton

D43219

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43219

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2576 E. Baltimore ST.; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Emilie Schmidt(a) RESIDENCE. NO. 2576 E. Baltimore ST., 6 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofChristian Schmidt

6 DATE OF BIRTH (month, day, and year)

Oct 31 1850

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.69613

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workAt home(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Hamburg
Germany

10 NAME OF FATHER

Deble11 BIRTHPLACE OF FATHER (city or town)
(State or country)Germany

12 MAIDEN NAME OF MOTHER

Lina Goldtman13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Germany

14

Informant
(Address)Miss Anna Schmidt
2576 E. Balto. St.

15

Filed

MAY 17 1920ROBERT I. KAUTER
Registrar

Baltimore Health Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 4, 1920, to May 13, 1920,that I last saw him alive on May 13, 1920,and that death occurred, on the date stated above, at 5:10 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(duration) yrs. mos. 9 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? Clinical examination(Signed) A. T. Reis, M. D.May 13, 1920 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Gen.May 17 1920

20 UNDERTAKER

ADDRESS

H. Sander Haus1710 Red St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Important. See instructions on back of certificate. Last statement of OCCUPATION is very important.

D43220

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43220

PLACE OF DEATH

CITY OF BALTIMORE (No. 204 in Curlew St.)

WARD

REGISTERED No. C

2-FULL NAME Emma Loomis

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 204 in Curlew

St. 28 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male	4-COLOR OR RACE white	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married
6-DATE OF BIRTH July 3 rd , 1880 (Month) (Day) (Year)		
7-AGE 40 ³ / ₉ yrs. 10 mos. 10 ds. If LESS than 1 day, hrs. or min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Laborer		
9-BIRTHPLACE, (State or Country). Harford Co. Md.		
PARENTS.	10-NAME OF FATHER Lorenze B. Loomis	
	11-BIRTHPLACE OF FATHER (State or Country). Pa.	
	12-MAIDEN NAME OF MOTHER Eliza Bougler	
	13-BIRTHPLACE OF MOTHER (State or Country). Md.	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Lhas L. Loomis
(Address) 5307 Rustictown Blvd

15-

MAY 17 1920

Filed

191

ROBERT F. KRAUTER

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held in charge of the (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicid. pistol shot

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Signed) [Signature] D.

(Coroner)

191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Druid Ridge Cem. May 27 1920

20-UNDERTAKER

ADDRESS

Henry Horck 1801 E Bay St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE
D4322P 137 D4322P
CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. 1402 N. Lakewood Ave. W. 8th WARD)

FULL NAME Louis Francis Klein

(Residence in Baltimore: No. 1410 N. Central Ave. St. yrs. mos. 6 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)
6 DATE OF BIRTH May 10, 1920 (Month) (Day) (Year)
7 AGE If LESS than 1 day, hrs. yrs. mos. 6 ds. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

MAY 17 1920

ROBERT E. KLAUTER

Barial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 16th, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 10th, 1920, to May 15th, 1920.

that I saw him alive on May 15th, 1920.

and that death occurred, on the date stated above, at 12⁴⁵ p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Atelectasis

Contributory (SECONDARY)

(Signed) Howard E. Wapner, M. D.

May 16th, 1920 (Address) 530 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery

May 17, 1920

20 UNDERTAKER

ADDRESS

Henry Horrell Son 1301 E. Bay St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43222

CERTIFICATE OF DEATH.

139 D43222
5 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 H. Alley ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1307 H. Alley St.; 22 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored5-~~SINGLE~~Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Not known, 1
(Month) (Day) (Year)

7-AGE,

22 yrs., 0 mos., 0 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

070
Housework9-BIRTHPLACE,
(State or Country),Maryland

PARENTS.

10-NAME OF FATHER,

Joe Corrish11-BIRTHPLACE OF FATHER
(State or Country),Unknown

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or Country),Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Wiess(Address) Johns Hopkins Hospital.

154

MAY 17 1920

ROBERT A. KRAUTER

Filed

191

Bureau of Health

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 13, 1920, to May 14, 1920,that I saw her alive on May 14, 1920,and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus following delivery of Obstetrical Case.(Duration) 0 yrs., 0 mos., 0 ds.CONTRIBUTORY
(Secondary)(Duration) 0 yrs., 0 mos., 0 ds.(Signed) E. P. Humeau M. D.191... (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Catholic Church

DATE OF BURIAL,

May 17, 1920

20-UNDERTAKER

Mrs. Geo. A. Hoopes

ADDRESS

406 1/2 Conway

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43223

CERTIFICATE OF DEATH.

40 D43223

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 S. Bond St ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Krizman(a) RESIDENCE. NO. 206 S. Bond St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 13 mos. 13 ds. How long in U. S., if of foreign birth? 13 yrs. 13 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofIsaac Krizman6 DATE OF BIRTH (month, day, and year) Jan 18847 AGE Years 44 Months — Days — If LESS than 1 day, hrs. — or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Russia10 NAME OF FATHER Mendel Wernickoff11 BIRTHPLACE OF FATHER (city or town)
(State or country)Russia12 MAIDEN NAME OF MOTHER Ida13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Russia

14

Informant
(Address)J. Leurs
1411 E. Balt St

15

Filed

MAY 17 1920ROBERT K. KRAUTER
RegistrarBarial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17th 19 20

17

I HEREBY CERTIFY, That I attended deceased from March-15, 19 20, to May 16, 19 20, that I last saw her alive on May 16, 19 20, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach(duration) yrs. 12 mos. — ds.CONTRIBUTORY none
(Secondary)(duration) yrs. — mos. — ds.18 Where was disease contracted
if not at place of death? —Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? X-ray Exam.(Signed) Herman Seidif, M. D., 19 (Address) 1931 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hehren Rosedale5/17 19 20

20 UNDERTAKER

ADDRESS

Jack Leurs1411 E. Balt St

N. B.—Every item of information should be carefully supplied. Age should be stated exactly. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D43224

D43224

PLACE OF DEATH

CITY OF BALTIMORE (No. 512 Bloom

ST 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Michael Lampe

(Residence in Baltimore: No. 512 Bloom

St. 17 yrs. 4 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX male 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED OR DIVORCED married (Write the word)

6-DATE OF BIRTH April 10, 1851 (Month) (Day) (Year)

7-AGE 69 yrs. 1 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Grocer 234 (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE Russia (State or country)

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER Russia (State or country)

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER Russia (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leon Lampe (Address) 512 Bloom St.

15. MAY 17 1920 ROBERT F. KRAUTER

Filed 191 BURIAL PLACE CITY REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 16, 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12, 1919, to May 16, 1920, that I saw him alive on May 16, 1920, and that death occurred, on the date stated above, at 7 P. m. The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 4 mos. 4 ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Nathan B. Borden M. D. May 16, 1920 (Address) 2114 Wilkens Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Balt Rebur May 17, 1920

20-UNDERTAKER ADDRESS

Jack Lewis 1411 E. Pratt

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43225

D43225

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 328 Park Ave ST. 11 WARD)

2-FULL NAME

(Residence in Baltimore: No. 328 Park Ave St.; 20 yrs., 0 mos., 0 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

M

4-COLOR OR RACE,

Chinese

5-SINGLE,

MARRIEDWIDOWEDOR DIVORCED

(Write the word.)

6-DATE OF BIRTH,

1871
(Month) (Day) (Year)

7-AGE,

49 yrs., 0 mos., 0 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country), China10-NAME OF FATHER, Han Long

11-BIRTHPLACE OF FATHER,

(State or Country), China12-MAIDEN NAME OF MOTHER, Mrs. Long Lee

13-BIRTHPLACE OF MOTHER,

(State or Country), China

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hou(Address) 328 Park Ave

15-

Filed

MAY 17 1920

ROBERT K. KRAUTER

BRIEF 23/10

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 16, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 14, 1920, to May 16, 1920,that I saw him alive on May 15, 1920, and that death occurred, on the date stated above, at P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(as far as I know)
(Duration).....yrs.....mos. 3 ds.CONTRIBUTORY
(Secondary)(Duration).....yrs.....mos.....ds.
(Signed) J. H. H. H. M. D.
, 191... (Address) 168 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore CemeteryMay 18, 1920

20-UNDERTAKER

ADDRESS,

John D. Mitchell

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43226

CERTIFICATE OF DEATH.

79 D43226
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2325 Madison Ave ST.; 13 WARD)

2-FULL NAME

Sallie Strasburger

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2325 Madison Ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, Married
MARRIED, WIDOWED, OR DIVORCED, (Write the words)6-DATE OF BIRTH, July 4, 1842
(Month) (Day) (Year)7-AGE, 77 yrs., 10 mos., 11 ds. IF LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 0379-BIRTHPLACE, (State or Country), Maryland10-NAME OF FATHER, Phillip Stern11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER Olisa Hartman13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwin Strasburger
(Address) 2325 Madison Ave

15-

Filed MAY 17 1920 ROBERT E. ELLIOTT
191. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 15, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 7, 1920, to May 14, 1920,
that I saw h er alive on May 15, 1920,
and that death occurred, on the date stated above, at 8:15 p.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
Chronic Endocarditis
(Duration) 10 yrs., mos., ds.

CONTRIBUTORY (Secondary)

Coronary atherosclerosis
(Duration) 7 yrs., mos., ds.
(Signed) J. Walk M. D.
May 16, 1920 (Address) 1278 D. Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Hebrew Friendship

DATE OF BURIAL,

May 17, 1920

20-UNDERTAKER

Jahrens & Co

ADDRESS

1611 Arad
ave

D43227

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43227

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hillsdale P.O. 28* ST.; *28* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John Howard Cowden*(Residence in Baltimore: No. *Hillsdale* St.; *1* yrs., *9* mos., *23* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word)*Single*

6-DATE OF BIRTH,

July 21, 1918
(Month) (Day) (Year)

7-AGE,

1 yrs., *9* mos., *23* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*None*9-BIRTHPLACE,
(State or Country),*City*

10-NAME OF FATHER,

*Jos. M. Cowden*11-BIRTHPLACE OF FATHER
(State or Country),*Penn*

12-MAIDEN NAME OF MOTHER

*Margaret K. Tudor*13-BIRTHPLACE OF MOTHER
(State or Country),*Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jos. M. Cowden*(Address) *Hillsdale P.O.*

15-

Filed

MAY 17 1920

ROBERT A. TRAUTER

Bureau of Health Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 16, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 10 1920, to *May 16* 1920that I saw him alive on *May 15* 1920and that death occurred, on the date stated above, at *7:20* p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) *6* yrs., *6* mos., *6* ds.CONTRIBUTORY
(Secondary)*Measles*
(Duration) *4* yrs., *4* mos., *4* ds.(Signed) *W. S. Hiblett* M. D.*May 17*, 1920 (Address) *3402 B. Street*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs., *9* mos., *23* ds. In the State *1* yrs., *9* mos., *23* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

Oak Lawn

DATE OF BURIAL,

May 17 1920

20-UNDERTAKER

Philip Herwig

ADDRESS

3016 Orleans

Important. See instructions on back of certificate.

D43228

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred	yrs.	mos.	ds.	How long in U. S., if of foreign birth?	yrs.	mos.	ds.
--	------	------	-----	---	------	------	-----

MEDICAL CERTIFICATE OF DEATH

20 UNDERTAKER	
	ADDRESS _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lowdon Park Cemetery	May 7, 1930

20 UNDERTAKER	ADDRESS
James D. Conant Son	1008 S. Paca

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43229

CERTIFICATE OF DEATH.

D43229

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 828 Granby ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Alexander M. Lubin

(a) RESIDENCE. No.

828 Granby ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofElizabeth Lubin

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.5-4not known

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

not known9 BIRTHPLACE (city or town)
(State or country)Lithuania

10 NAME OF FATHER

George Lubin

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Lithuania

12 MAIDEN NAME OF MOTHER

not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Lithuania

14

Informant
(Address)Elizabeth Lubin
828 Granby St.

15

Filed

MAY 17 1920ROBERT F. KAUTER

Registrar

Boris

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 13 1920 to May 15 1920.that I last saw him live on May 16 1920.and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema(duration) yrs. 1 mos. 1 ds.CONTRIBUTORY Chronic Valvular Disease
(Secondary)(duration) yrs. 2 mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical signs(Signed) J. B. Bronusnas, M. D.5-16, 1920 (Address) 615 Columbia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cem.May 18 1920

20 UNDERTAKER

ADDRESS

John Greblanchas425 S. Pa
St.

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43230

D43230

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 855 W Lombard St. 18 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 855 W Lombard St. WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

FILE

MAY 17 1920

ROBERT A. KRAUTER

Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

HEREBY CERTIFY, That I attended deceased from
May 4, 1920, to May 16, 1920,
that I last saw her alive on May 16, 1920,
and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Meningitis,

CONTRIBUTORY
(Secondary)18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

5720 (Address)

State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

May 18 1920

20 UNDERTAKER

ADDRESS

John Gubliancas 425 S. Prager

TION is very important. See instructions on back of certificates.

D43231

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 D43231

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 N Paca ST.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Elizabeth Holt(Residence in Baltimore: No. 124 N Paca St.; 0 yrs., 0 mos., 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female4-COLOR OR RACE, White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single
(Write the word.)6-DATE OF BIRTH, May 13, 1920

(Month)

(Day)

(Year)

7-AGE, 0 yrs., 6 mos., 9 ds.If LESS than 1 day,
hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto Md10-NAME OF FATHER Albert Holt11-BIRTHPLACE OF FATHER (State or Country), Balto12-MAIDEN NAME OF MOTHER Grace May Holt13-BIRTHPLACE OF MOTHER (State or Country), Camden N.J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Holt(Address) 124 N Paca

15-MAY 17 1920

ROBERT E. RAUTER

Filed....., 191.....

BALTIMORE HEALTH DEPARTMENT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 16, 1920

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from May 15, 1920, to May 16, 1920,that I saw her alive on May 15, 1920,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Non closure of foramen
Coch.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Electrocardiogram

(Duration) yrs. mos. ds.

(Signed) R.R. Kenyon M. D.May 16, 1920 (Address) 609 W Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park BurDATE OF BURIAL, May 18, 192020-UNDERTAKER David FarberADDRESS 916

CAUSE OF DEATH in plain text, so that it may be properly important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43232

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

101

ROBERT E. KRAUTER

BRIAL FIRM Reg 14720

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

May 10th 1920, to May 11th 1920,that I saw her alive on May 11th 1920,and that death occurred, on the date stated above, at 6¹⁵ A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) John H. H. M. D.

May 16th 1920. (Address) 1243 N. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 5 yrs. mos. ds. In the 52 yrs. mos. ds. State

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Cemetery May 17, 1920

20-UNDERTAKER

ADDRESS

Joseph L. B. Cook 1003 N. Balto St.

important. See instructions on back of certificate.

D43233

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43233

PLACE OF DEATH

CITY OF BALTIMORE (No. *Wadmore* 408 York St. *12*, WARD)2-FULL NAME *Charles W. Peterson*(Residence in Baltimore: No. *4500 York Rd.*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *12* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*4-COLOR OR RACE, *white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*6-DATE OF BIRTH, *July 7, 1894*7-AGE, *75* yrs. *10* mos. *17* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Wholesale*
(b) General nature of industry, business, or establishment in which employed (or employer). *007*9-BIRTHPLACE, (State or Country), *Balto*10-NAME OF FATHER, *John Peterson*11-BIRTHPLACE OF FATHER, (State or Country), *MD*12-MAIDEN NAME OF MOTHER, *Alice Kirkwood*13-BIRTHPLACE OF MOTHER, (State or Country), *MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Dr. Emily Peterson*(Address) *4500 York Rd.*

15-

MAY 17 1920

ROBERT A. KRAUTER

Filed

191

Bureau of Health

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 16, 1920*

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

fracture of hip by street car
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Wm. H. Dudley* M. D. (Coroner.)Address) *4 E. 1st*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL, *May 18, 1920*

20-UNDERTAKER

ADDRESS

John H. Hargis & Co. 2008 Orleans

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43234

D43234

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 Upton

ST.: 17 WARD)

2-FULL NAME

William J. Lee

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 1217 Upton

(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Colored Married

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Emma Lee

6 DATE OF BIRTH (month, day, and year)

Mar. 27, 1866

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

53 -

5

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

Driver Lumber Wagon

(c) Name of employer

Mother

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Charles Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Francis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Emma Lee

(Address) 1217 Upton

15

MAY 17 1920

ROBERT A. KRAUTER Registrar

Burial Permit 01071

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1920

17

I HEREBY CERTIFY, That I attended deceased from March 20, 1920, to April 16, 1920, that I last saw him alive on March 15, 1920, and that death occurred, on the date stated above, at 9.45 A.M. The CAUSE OF DEATH* was as follows:

Mitral Regurgitation & Atherosclerosis (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Acute Gastritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Baltimore, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam. & Blood

(Signed) William H. Huggins, M. D.

1719 20 (Address) 1209 Presbiterian

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn Cem. May 18 1920

20 UNDERTAKER

ADDRESS

Wm. H. Chase & Son 1400 Madison

D43235

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43235

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *12th* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *1015 P. Robinson St.* ST. *Life* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

Divorced (write the word)*child*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *July 2, 1913*

7 AGE

Years

Months

Days

If LESS than
1 day. hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant
(Address)

15

File

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-16* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from
May 15, 19*20*, to *May 16*, 19*20*,
that I last saw him alive on *May 16*, 19*20*,
and that death occurred, on the date stated above, at *9 05 a.m.*

The CAUSE OF DEATH* was as follows:

*Mostoiditis salitis media
rt*

CONTRIBUTORY

Secondary

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?*Prs home*

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

Wm. H. Harrison

M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Rosary Cem**May 18 20*

20 UNDERTAKER

Stephen J. Pealkowski

ADDRESS

1001 N. Howard St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

MAY 17 1920

D43236

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43236

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2141 Walbrook Ave. ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2141 Walbrook Ave St.; 78 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Oct 31, 1837
(Month) (Day) (Year)

7-AGE,

83 yrs., 5 mos., 14 ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

Black-smith

(b) General nature of industry, business, or establishment in which employed (or employer).....

City Water Dept.

9-BIRTHPLACE,

(State or Country),

Ireland

10-NAME OF FATHER,

William Carr

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Jane Heir

13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Matilda A Carr(Address).....2141 Walbrook Ave

15-

MAY 17 1920 Robert P. Harrison,
Filed..... 191.....
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 10 1920, to May 15 1920,that I saw him alive on May 14 1920,and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

.....

.....Wascum's Corns.....

.....

.....

.....(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

.....(Duration)..... yrs. mos. ds.

(Signed).....G. L. Ewell..... M. D.May 17, 1920 (Address).....905 N. Wilma St.

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important. See instructions on back of certificate.

D43237

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 S. Caroline ST.; 3 WARD)2-FULL NAME Baby Newman(Residence in Baltimore: No. 314 S. Caroline St.; ✓ yrs., ✓ mos. 12 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Male</u>	4-COLOR OR RACE. <u>Black</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
6-DATE OF BIRTH, <u>April 30</u> , 19 <u>20</u> (Month) (Day) (Year)		
7-AGE, <u>✓</u> yrs., <u>✓</u> mos., <u>12</u> ds.		If LESS than 1 day, <u>✓</u> hrs. or <u>✓</u> min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		

PARENTS.	9-BIRTHPLACE, (State or Country), <u>MD</u>
	10-NAME OF FATHER, <u>Henry Adams</u>
	11-BIRTHPLACE OF FATHER (State or Country), <u>MD</u>
	12-MAIDEN NAME OF MOTHER, <u>Catherina Newman</u>
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Washington D.C.</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hospital.
(Address)

15-

Robert P. Harrison, REGISTRAR.
Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH May 11, 1920
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from April 30, 1920, to May 11, 1920, that I saw him alive on May 10, 1920, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.
(Duration) 0 yrs., 0 mos., 2 ds.CONTRIBUTORY (Secondary) ✓(Signed) E. E. Harrison M. D.
(Address) Johns Hopkins Hospital, 191...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ✓ yrs., ✓ mos., ✓ ds. In the State ✓ yrs., ✓ mos., ✓ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL DATE OF BURIAL, May 15, 192020-UNDERTAKER, Commissioner ADDRESS

important. See instructions on back of certificate.

D43238

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 43238

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 613 modricad ST.)

2-FULL NAME

Carrie Barnes

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 613 modricad ST.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

col

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Dec 27 1915

7-AGE,

4 yrs. 19 mos. 19 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Maryland

10-NAME OF FATHER,

Joseph Barnes

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Mary Louise

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joseph P. Harrison

(Address)

613 modricad ST.

15-

Robert P. Harrison,

1915

191

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Mar 16 1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

(Coroner.)

J. P. Harrison

191 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

In the

of death....yrs....mos....ds. State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Asbury Cemetery May 18, 1920

Milton Davis 1312 5th ST

important. See instructions on back of certificate.

MAY 17 1920

D43239

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43239

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *709 Curtis Ave* St.; *25* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *709 Curtis Ave* St.; *1* yrs. *5* mos. *5* da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

Dec 13, 1919
(Month) (Day) (Year)

7-AGE.

1 yrs. *5* mos. *3* da.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....9-BIRTHPLACE,
(State or Country)*Curtis Bay*10-NAME OF FATHER *Frank Kasubyski*11-BIRTHPLACE OF FATHER (State or Country) *Russia, Poland*12-MAIDEN NAME OF MOTHER *Josef Kasubyski*13-BIRTHPLACE OF MOTHER (State or Country) *Russia, Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank Kasubyski*(Address) *709 Curtis Ave*

15-

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 16, 1920
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
May 13 191, to *May 16* 1920,
that I saw him alive on *May 16* 1920,
and that death occurred, on the date stated above, at *6:40 p.m.*

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

.....

..... (Duration) mos. *1* dayCONTRIBUTORY (Secondary) *Measles*..... (Duration) yrs. *3* da.(Signed) *Dr. B. H. Harrison* M. D.*May 17, 1920* (Address) *Cedar St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Cross

20-UNDER

Dr. P. Kasubyski

DATE OF BURIAL,

3/18, 1920

ADDRESS

118 East...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation, if any, important. See instructions on back of certificate.

MAY 17 1920

D43240

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43240

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414. S. Lusham ST. WARD) V

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Boleslaw Perkowski

(a) RESIDENCE. NO.

414. S. Lusham ST.

WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 15-1901

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.18700

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Business at home

(b) General nature of industry, business, or establishment in which employed (or employer)

At home

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Poland

10 NAME OF FATHER

Joseph Perkowski11 BIRTHPLACE OF FATHER (city or town)
(State or country)Poland

12 MAIDEN NAME OF MOTHER

Eliza Tamm13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)Eliza Perkowski
414 S. Lusham

15

Filed

by

Robert F. H. H. H.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 16 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 6, 1920, to May 16, 1920,that I last saw him alive on May 15, 1920,and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis, pericarditis
Molecular fibrils(duration) yrs. mos. 21 ds.CONTRIBUTORY
(Secondary)Acute Cardiac Dilatation(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

unknown

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

findings(Signed) F. F. R. R. R. M. D.5-16-1920 (Address) 200 N. Patterson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary5/18 1920

20 UNDERTAKER

ADDRESS

William Fialkowski 100 East

MAY 17 1920

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43241

CERTIFICATE OF DEATH.

81 ✓ D43241

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2520 Brookfield Ave ST.: 13 WARD)

2-FULL NAME

Rebecca Adler

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

2520 Brookfield Ave ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 50 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofAbraham Adler

6 DATE OF BIRTH (month, day, and year)

May 9 1835

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.81-8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Abraham Prag

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Ella Strauss

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant
(Address)Edward Sonnenhill
2520 Brookfield Ave

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1920

17

I HEREBY CERTIFY, That I attended deceased from

Jan, 1920, to May 16, 1920,that I last saw him alive on May 16, 1920,and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Atherosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

edema of lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) J. Frederick Smith, M. D.5/17, 1920 (Address) 7040 Eutan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Friendship 5/19 1920

20 UNDERTAKER

ADDRESS

J. Ahrens Co1611 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 17 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43242

CERTIFICATE OF DEATH.

D43242

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 S. Wolf St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 116 S. Wolf St.; 46 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widw
(Write the word.)

6-DATE OF BIRTH, Unk. Nov. 1848
(Month) (Day) (Year)

7-AGE, 71 yrs., mos. ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Home work
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Poland

10-NAME OF FATHER, Wagne
11-BIRTHPLACE OF FATHER (State or Country), Poland
12-MAIDEN NAME OF MOTHER, Unk. name
13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mein. Sadowski
(Address) 705 S. Ann St.

15-

Robert P. Harrison,

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 16, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 13, 1920, to April 28, 1920, that I saw h. alive on April 28, 1920, and that death occurred, on the date stated above, at 1 a.m.
The CAUSE OF DEATH* was as follows:

Acute Indigestion
(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Nephritis
(Duration) yrs. 2 mos. ds.

(Signed) J. J. Sadowski, M. D.
5.17.1920. (Address) 722 S. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus, DATE OF BURIAL, May 19, 1920.

20-UNDERTAKER, M. F. Sadowski, ADDRESS, 705 S. Ann St.

important. See instructions on back of certificate.

MAY 17 1920

D43243

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43243

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 S. Greenwood Ave. ST. 1 WARD)

2-FULL NAME

Wincenza Kuchta

(Residence in Baltimore: No. 1118 S. Greenwood Ave. 27 yrs., - mos. - ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

Unknown - 1855

7-AGE,

65

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

at home

9-BIRTHPLACE, (State or Country).

Poland.

10-NAME OF FATHER,

Gapinski.

11-BIRTHPLACE OF FATHER (State or Country).

Poland.

12-MAIDEN NAME OF MOTHER

Unknown.

13-BIRTHPLACE OF MOTHER (State or Country).

Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antony Kuchta, Son.

(Address) #1118 S. Greenwood Ave.

15-

Robert P. Harrison,

MAY 17 1920

Burial permit clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 15, 1920.

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from April 4, 1920, to April 23, 1920.

that I saw her alive on April 23, 1920,

and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Chronic asthma

mitral regurgitation

(Duration) Unknown

CONTRIBUTORY (Secondary)

(Duration) Unknown

(Signed) M. J. Harrison, M.D.

May 15, 1920 (Address) 2431 Fair

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

May 18, 1920.

20-UNDERTAKER

M. F. Sadowski

ADDRESS

405 S. Ann St.

D43244

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43244

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *McHone Retmar*)ST. *28th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Louisa R. Paff*(a) RESIDENCE. NO. *Savannah Ga.*

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *7* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) *July 11th 1855*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

65

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Savannah Ga.*
(State or country)10 NAME OF FATHER *John Becker*11 BIRTHPLACE OF FATHER (city or town) *Petersham*
(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Madeline Michell*13 BIRTHPLACE OF MOTHER (city or town) *Baden*
(State or country) *Germany*14 Informant *Records of McHone Retmar*
(Address) *McHone Retmar, Md.*15 *Robert P. Harrison,*

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-17* 19 *20*

17 I HEREBY CERTIFY, That I attended deceased from *July 11th* 1913 to *May 17th* 1920, that I last saw her alive on *May 16th* 1920, and that death occurred, on the date stated above, at *3 A.* m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis
(with perforation & collapse)

(duration) *0* yrs. *0* mos. *3* ds.CONTRIBUTORY *Chronic Mania*
(Secondary) *abs*(duration) *11* yrs. *0* mos. *0* ds.18 Where was disease contracted *Savannah Ga.*
if not at place of death?Did an operation precede death? *No* Date of _____Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Frank J. Flannery* M. D.May 17 1920 (Address) *McHone Retmar - Baltimore, Md.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Savannah Ga. *May 17/ 1920*20 UNDERTAKER
STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)ADDRESS
108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 17 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43245

D43245

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Faith Lane ST. 8 WARD)

2-FULL NAME

(a) RESIDENCE. No. 1617 Faith Lane ST. 8 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 50 yrs.

mos.

ds.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAY 18 1920

ROBERT B. LAUTER

Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from May 10 to May 16 1920, that I last saw him live on May 16 1920, and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Harry H. A. Meyer, M.D.

(Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

May 18 1920

20 UNDERTAKER

ADDRESS

Harry Lutz

1007 Bond

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D43246

CERTIFICATE OF DEATH.

41 D43246
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *118 Pearl St*)ST.; *4* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *118 Pearl St*)

St.;yrs.mos.ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Widow*

6-DATE OF BIRTH,

Jan 1-

(Month)

(Day)

1828

(Year)

7-AGE,

92 yrs. *4* mos. *17* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),*Baltimore Md*

10-NAME OF FATHER,

*Wm H. Fowler*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore Md*

12-MAIDEN NAME OF MOTHER

*Mary Green*13-BIRTHPLACE OF MOTHER
(State or Country),*Baltimore Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Grace Lee*(Address) *118 Pearl St*

15-

MAY 18 1920

ROBERT B. BRAUTER

Filed.....

191..

Baltimore

City of

Maryland

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*May**17**1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July**1910*to *May 17**1920*that I saw her alive on *May 17* *1920*,and that death occurred, on the date stated above, at *7:15 a. m.*

The CAUSE OF DEATH* was as follows:

*Carcinoma of Colon**at least*

(Duration).....yrs.mos.ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.mos.ds.

(Signed).....*Geo. T. Kemp*.....M. D.*May 17*....., 1912. (Address) *St. James Apartment*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Sandon Park

DATE OF BURIAL,

5/18/20, 191...

20-UNDERTAKER

Geo. J. Smith

ADDRESS

1000 N. Fayette

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43242

D43242

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 Falls Road 13 ST. 13 WARD)

2-FULL NAME

Edward A. Buchman

(a) RESIDENCE. No. 1809 Falls Road ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

Mrs Mary E Buchman

6 DATE OF BIRTH (month, day, and year)

July 5th 1862

7 AGE

Years

Months

Days

57

9

11

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

Pick & shovel

(c) Name of employer

1

9 BIRTHPLACE (city or town) (State or country)

Westminster Maryland U.S.A

10 NAME OF FATHER

Edward Buchman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Carroll Co Maryland

12 MAIDEN NAME OF MOTHER

Julia Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Carroll Co Maryland U.S.A

14

Informant (Address)

Mary E Buchman 1809 Falls Road

15

MAY 18 1920

ROBERT A. ELSTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 16 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 16, 1920, to May 16, 1920

that I last saw him alive on May 16, 1920

and that death occurred, on the date stated above, at 9:55 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald J. Toney, M. D.

, 19 (Address) 414 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Marys Hampden May 18 1920

20 UNDERTAKER

ADDRESS

Chenoweth Son Chestnut Ave

CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43248

CERTIFICATE OF DEATH.

81

D43248

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1705 Druid Hill Rd* ST. *14* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1705 Druid Hill* *Rd.* yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH, *Unknown*, 1 *910*
(Month) (Day) (Year)

7-AGE, *75* yrs. — mos. — ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Elkridge Md.*

10-NAME OF FATHER, *Geo. W. Williams*

11-BIRTHPLACE OF FATHER (State or Country), *Ta.*

12-MAIDEN NAME OF MOTHER *Amelia Mansfield*

13-BIRTHPLACE OF MOTHER (State or Country), *Elkton Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Fannie Johnson*(Address) *1705 Druid Hill Ave*

15- *MAY 18 1920* *ROBERT F. ERAUTER*

Filed, 191. *Burial* *Record*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 15, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 11, 1920*, to *May 15, 1920*, that I saw her alive on *May 15, 1920*, and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows: *Cerebral Atherosclerosis*

(Duration)..... yrs. mos. ds.

CONTRIBUTORY..... (Secondary) *Coronary*

(Duration)..... yrs. mos. ds.

(Signed) *W. J. Carr* M. D. *May 17, 1920* (Address) *515 Mosher*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Laurel Ave* DATE OF BURIAL, *May 18, 1920*

20-UNDERTAKER *Samuel J. ...* ADDRESS *3811 ...*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43249

CERTIFICATE OF DEATH.

41 D43249
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Helena Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 311 S. Eden St. St.; 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, married
(Write the word.)6-DATE OF BIRTH, June, 1888
(Month) (Day) (Year)7-AGE, 35 yrs., mos. ds. If LESS than 1 day,hrs. ormin.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housewife
(b) General nature of industry, business, or establishment in which employed (or employer), 0379-BIRTHPLACE, (State or Country), Russia10-NAME OF FATHER, Hessel Miller11-BIRTHPLACE OF FATHER (State or Country), Russia12-MAIDEN NAME OF MOTHER, Sarah Ella13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), J. Lewis
(Address), 1411 E. Baltimore

MAY 18 1920

Filed..... 191. ROBERT E. LAUTER

Burial in the Regent

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May, 17, 1917
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 1, 1917, to May 17, 1917, that I saw h. alive on May 17, 1917, and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis of Liver
(Duration).....yrs.. mos. ds.CONTRIBUTORY.....
(Secondary)(Signed), Br. J. Sacks, M. D.
May 17, 1920 (Address), Helena Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death? ?Former or usual residence 311 S. Eden

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Helena Hospital, 3/17, 1917

20-UNDERTAKER, ADDRESS

Jack Lewis, 1411 E. Baltimore

important. See instructions on back of certificate.

D43250

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D43250
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 S. Collington St.; WARD)

2-FULL NAME Elsie G. Rylander

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 229 S. Collington St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH, *Sept 24*, 1897
(Month) (Day) (Year)

7-AGE, *22* yrs. *7* mos. *24* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... *Drug Dept*
(b) General nature of industry, business, or establishment in which employed (or employer)..... *McCormick & Co*

9-BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER, *Chas Rylander*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER *Barbara Sharnan*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Barbara Rylander*

(Address) *229 S. Collington St.*

MAY 18 1920

ROBERT H. KRAUTER

Filed..... 191... *Barbara Rylander*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *May 15*, 1918
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Nov. 18* 191*8*, to *May 10* 191*8*, that I saw her alive on *May 10* 191*8*, and that death occurred, on the date stated above, at *11:30* m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration)..... yrs. *10* mos. ds.

CONTRIBUTORY (Secondary) *La Grippe*
(Duration)..... yrs. *1 1/2* mos. ds.

(Signed) *Geo. Heller* M. D.
....., 191... (Address) *1937 E. 1st St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Swansea Cemetery *May 14, 1920*

20-UNDERTAKER ADDRESS

Hendell & Gippel *37 S. Emden*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43251

CERTIFICATE OF DEATH.

108 D43251

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. *Mercy Hospital* ST. *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *2132* ST. *W. Culley* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. ds. How long in U. S., if of foreign birth *life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Black* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *James*

6 DATE OF BIRTH (month, day, and year) *March 18, 1892*

7 AGE *28* Yrs. Months *2* Days *2* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Butler 070*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Virginia*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Virginia*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Virginia*

14

Informant (Address) *Mercy Hospital City*

15

Filed

MAY 18 1920

ROBERT B. KRAUTER

Registrar

Serial Permit 01021

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 18 1920*

17 I HEREBY CERTIFY, That I attended deceased from *May 13, 1920*, to *May 18, 1920*, that I last saw him alive on *May 18, 1920*, and that death occurred, on the date stated above, at *4¹⁵ A.M.* The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. ds. CONTRIBUTORY (Secondary) *Appendicitis* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *May 13*

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *J. D. Ridgely* M. D.

. 19 (Address) *Mercy Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Griffiths Cemetery Co. Joppa, Md.

May 19 1920

UNDERTAKER

ADDRESS

Charles E. Wright 1364 Carey St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43252

CERTIFICATE OF DEATH.

91 D43252

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 S Broadway ST.: 3 WARD)2-FULL NAME Irma May Giewerth

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 12 S. Broadway ST., 3 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 23 19197 AGE Years Months Days If LESS than 1 day, hrs. or min. 4 23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 800(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md (State or country)10 NAME OF FATHER Arthur C. Giewerth11 BIRTHPLACE OF FATHER (city or town) Balto, Md (State or country)12 MAIDEN NAME OF MOTHER Ida May Gollinghorst13 BIRTHPLACE OF MOTHER (city or town) Balto, Md (State or country)14 Informant Arthur C. Giewerth (Address) 12 S. Broadway15 MAY 18 1920 ROBERT F. KRATTEN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 192017 I HEREBY CERTIFY, That I attended deceased from May 14, 1920, to May 16, 1920, that I last saw him alive on May 16, 1920, and that death occurred, on the date stated above, at 3:00 m.

The CAUSE OF DEATH* was as follows:

Pericarditis(duration) yrs. mos. ds. 3

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? Autopsy(Signed) J. H. Hentz, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Robert F. Kratten May 18 1920
Low's Heermann 320 Broadway

CAUSE OF DEATH IN PAINTED TERMS, so that it may be properly classified. STATE DEPARTMENT OF HEALTH. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43253

140 743253

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *John Hopkins Hospital* ST.: *10th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Eta Rogers*(a) RESIDENCE. NO. *933 Somerset St.* ST. *10th* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *Life* mos. *10* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *+*6 DATE OF BIRTH (month, day, and year) *Oct. 1 - 1855*7 AGE Years *64* Months *7* Days *18* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *unknown*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Maryland* (State or country)10 NAME OF FATHER *Richard Hopkins*11 BIRTHPLACE OF FATHER (city or town) *Maryland* (State or country)12 MAIDEN NAME OF MOTHER *Mary* —13 BIRTHPLACE OF MOTHER (city or town) *Maryland* (State or country)14 Informant *J. H. H. Records* (Address)15 *MAY 18 1920* ROBERT A. KRAUTER Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 16* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

May 10, 19*20*, to *May 16*, 19*20*,that I last saw her alive on *May 16*, 19*20*,and that death occurred, on the date stated above, at *10* a. m.

The CAUSE OF DEATH* was as follows:

Acute lobar pneumonia(duration) yrs. mos. *10* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? *?* if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *yes*(Signed) *Robert A. Krauter*, M. D.19 (Address) *John Hopkins*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Rock Run Cem. Harford *May 19* 19*20*

20 UNDERTAKER

Wm. L. Black 927 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D43254

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43254

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *9th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Paul Hansen(a) RESIDENCE, No. *1530 Hamstead* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Infant*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Infant*6 DATE OF BIRTH (month, day, and year) *March 26-1920*7 AGE Years *1* Months *2* Days *1* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.* (State or country)10 NAME OF FATHER *Wm Hansen*11 BIRTHPLACE OF FATHER (city or town) *B. J.* (State or country)12 MAIDEN NAME OF MOTHER *Elizabeth Jones*13 BIRTHPLACE OF MOTHER (city or town) *Md.* (State or country)14 Informant *Hospital Record* (Address) *J. H. 26*

15 MAY 18 1920 ROBERT A. KRAUTER Registrar

Basil Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 17* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

April 16, 19*20*, to *May 17*, 19*20*.that I last saw him alive on *May 17*, 19*20*.and that death occurred, on the date stated above, at *4:05* p. m.

The CAUSE OF DEATH* was as follows:

Congenital structure of the urethra.(duration) yrs. *1* mos. *2* ds.

CONTRIBUTORY (Secondary)

None.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *Congenital*Did an operation precede death? *Yes* Date of *May 14, 1920*Was there an autopsy? *No*What test confirmed diagnosis? *Operation.*(Signed) *Harold K. Higgins* M. D.5/17/1920 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*NEW CATHEDRAL**MAY 19 1920*

20 UNDERTAKER

ADDRESS

*JOHN F. BENNY**715 LIGHT ST*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43255

CERTIFICATE OF DEATH.

79 D43255

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1408 N. Gay* ST.: *8* WARD) *8*

2-FULL NAME

(a) RESIDENCE. No. *1408 N. Gay* ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *47* yrs. *9* mos. *26* ds.(If nonresident give city or town and State)
How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*White*5 Single, Married, Widowed,
or Divorced (write the word)*Married*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Minnie Graham*

6 DATE OF BIRTH (month, day, and year)

July 22 - 1872

7 AGE

Years

Months

Days

If LESS than
1 day, — hrs.
or — min.*47**9 26*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Clerk 009*(b) General nature of industry,
business, or establishment in
which employed (or employer)*Retail Grocer*

(c) Name of employer

*Bethlehem Steel Co.*9 BIRTHPLACE (city or town)
(State or country)*Balt. Md.*

10 NAME OF FATHER

*Wm. J. Graham*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Balt. Md.*

12 MAIDEN NAME OF MOTHER

*Ellie A. Jones*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Balt. Md.*

14

Informant

(Address)

*Mrs. Ellie A. Graham**1508 E. Federal St.*

15

Filed

*MAY 18 1920**ROBERT A. KRAUTER**Burial Permit 01555*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 17th 1920

17

HEREBY CERTIFY, That I attended deceased from

May 16th 1920, to *May 17th 1920*,that I last saw him alive on *May 16th 1920*and that death occurred, on the date stated above, at *12⁴⁵ A. M.*

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) — yrs. — mos. — ds.

CONCOMITANT (Secondary) *Prone Valvular Heart dis.*

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date of —Was there an autopsy? *no*What test confirmed diagnosis? *Clinical*
signed *Albert A. Meyer*, M. D.(Address) *1031 N. Caroline St.**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*WESTERN**MAY 19 1920*

20 UNDERTAKER

ADDRESS

*JOHN F. DENNY**715 LIGHT ST*Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE SHOULD BE
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION
TION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43256

CERTIFICATE OF DEATH

64

D43256

1-PLACE OF DEATH

CITY OF BALTIMORE (NO.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

IF LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country)

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAY 18 1920

ROBERT B. KRAUTER

101

Register.

Dr. Riley 139 N. Broadway

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and, from the evidence obtained by said (Inquest, au-

topsy or inquiry,) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

May 17, 1920 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43257

CERTIFICATE OF DEATH

D43257

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

5 yrs.

mos.

ds. How long in U. S., if of foreign birth?

WARD.

(If nonresident, give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Harry D. Dawson

6 DATE OF BIRTH (month, day, and year)

Jan 18 1898

7 AGE

Years

Months

Days

20

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

George Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

12 MAIDEN NAME OF MOTHER

Annie Sauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

14

Informant (Address)

Harry D. Dawson
1903 Patterson Pl.

15

MAY 18 1920

ROBERT B. ELLIOTT

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 13 1920, to May 17 1920,

that I last saw her alive on May 17 1920,

and that death occurred, on the date stated above, at 10:20 p.m.

The CAUSE OF DEATH* was as follows:

Pelvic peritonitis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

J. B. Brown has M. D.

Address) 17, 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Cross

DATE OF BURIAL

May 20 1920

20 UNDERTAKER

William Cook

ADDRESS

502 S. North

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43258

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43258

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Belvedere Hotel* ST.: *9* WARD)

2-FULL NAME

John L. Burgess

(Residence in Baltimore: No. *2001 Greenmount Ave.* St. *4th* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word)

Married

6-DATE OF BIRTH,

April 20, 18*60*
(Month) (Day) (Year)

7-AGE,

60 yrs. *26* mos. *26* ds.

If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Time Keeper
000

9-BIRTHPLACE,
(State or Country),

Balto Md

PARENTS.

10-NAME OF FATHER,

Don't know

11-BIRTHPLACE OF FATHER
(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER
(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary E. Burgess*

(Address) *2001 Greenmount Ave.*

15-

ROBERT B. TRAUTER

MAY 18 1920 191. *8-11-12* *Pat. Off.* *Class.*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 16, 19*20*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest and that said deceased came to *his* death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Anginal Pectoris

Duration (Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. H. Riley* M. D.

(Coroner.)

May 7, 1920 (Address) *1639 Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

May 18 1920

20-UNDERTAKER

William Cook

ADDRESS

502 E. North Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43259

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *James Hopkins Hospital* ST.: *5th* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *735 N. Eden St.* ST. *North Carolina* WARD. *North Carolina*(Usual place of abode) *North Carolina* (If nonresident give city or town and State)Length of residence in city or town where death occurred yrs. *3* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 2, 1892*7 AGE Years *28* Months *unknown* Days *unknown* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *+ 070*(b) General nature of industry, business, or establishment in which employed (or employer) *maid*(c) Name of employer *unknown*9 BIRTHPLACE (city or town) (State or country) *North Carolina*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Wilson ?* *unknown* *North Carolina*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Griffin* *Virginia*

14

Informant (Address) *2444 Records*

15

MAY 18 1920

ROBERT E. KRAUTER

Registrar
Burial Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 16 1920*17 I HEREBY CERTIFY, That I attended deceased from *May 14*, 1920, to *May 16*, 1920, that I last saw her alive on *May 16*, 1920, and that death occurred, on the date stated above, at *11 a* m.

The CAUSE OF DEATH* was as follows:

Encephalitis lethargica(duration) yrs. mos. *10* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *?*Did an operation precede death? *no* Date of *May 16, 1920*Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *J. G. Motter* M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

North West Norfolk Co. Va. May 20 20

20 UNDERTAKER

Chris. H. Johnson 467, Calver St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43260

D43260

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1830 Bolton ST.; 1st WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E. Anderson(Residence in Baltimore: No. 1830 Bolton St.; 8 yrs., 8 mos., 8 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Oct 23 (Month) 1871 (Year)

7-AGE,

48 yrs. 6 mos. 25 ds.If LESS than 1 day,
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).At Home9-BIRTHPLACE,
(State or Country),Kent Md

10-NAME OF FATHER,

Albert Anderson11-BIRTHPLACE OF FATHER
(State or Country),Caroline St

12-MAIDEN NAME OF MOTHER

Annie E. Connolly13-BIRTHPLACE OF MOTHER
(State or Country),Caroline St

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eva Connolly(Address) 1830 Bolton St

15-

MAY 18 1920

ROBERT A. TRAUBER

Filed

1st. Bertel Clark
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 18, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 20 1920, to May 18 1920, that I saw her alive on May 16 1920, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis -CONTRIBUTORY
(Secondary)(Duration) many yrs. 3 mos. 8 ds.(Signed) Chas. TurnerMay 16, 1920 (Address) 1327 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 8 yrs. 8 mos. 8 ds. In the State 8 yrs. 8 mos. 8 ds.

Where was disease contracted, if not at place of death?

Former usual residence

Westminster

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

Kent MdMay 20, 1920

20-UNDERTAKER

ADDRESS

William Cook1327 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

D43261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43261

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johas Hopkins Hospital ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas F. Alston(a) RESIDENCE. NO. Dues, Warren Co., North Carolina ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

+

6 DATE OF BIRTH (month, day, and year)

2

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Dues, North Carolina

10 NAME OF FATHER

Archibald Davis Alston

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Dues, North Carolina

12 MAIDEN NAME OF MOTHER

Winona Florida Alston

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Halifax Co., North Carolina

14

Informant (Address)

J.H. Bonds

15

19

Robert F. [illegible]

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-17 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 14, 1920, to May 17, 1920,that I last saw him alive on May 17, 1920,and that death occurred, on the date stated above, at 8:45 p. m.

The CAUSE OF DEATH* was as follows:

chronic nephritis
arteriosclerosis
hypertension

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

Uremia(?)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

?Did an operation precede death? No Date of Was there an autopsy? Yes

What test confirmed diagnosis?

Autopsy, Laboratory

(Signed)

Schumacher

M. D.

19 (Address)

Johas Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Karlina N.C.May 18 1920

20 UNDERTAKER

Joseph Ahrens

ADDRESS

221 N. Bay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

MAY 18 1920

D43262

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43262

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *29156 Monument* ST.: *7* WARD)

2-FULL NAME

Ella Roberts

(a) RESIDENCE

NO. *29156 Monument* ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *16* yrs. *4* mos. *8* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Jan. 7th 1904*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
16 *4* *8*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto. Ind.*

10 NAME OF FATHER

*Henry Roberts*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto. Ind.*

12 MAIDEN NAME OF MOTHER

*Elizabeth Hartman*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto. Ind.*

14

Informant

(Address)

*Elizabeth Roberts**29156 Monument**Robert P. Harrison,**Burial Permit Clerk.*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 15th 1920*

17

I HEREBY CERTIFY, That I attended deceased from *April 4th 1920*, to *May 15th 1920*, that I last saw her alive on *May 15th 1920*, and that death occurred, on the date stated above, at *9:40 p.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.(duration) yrs. *1* mos. *11* ds.

CONTRIBUTORY (Secondary)

Acute Edema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*unknown*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

findings(Signed) *Fred R. Ruzicki*, M. D.5-18 1920 Address *800 N. Patterson St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Oak Lawn Cem.**May 19th 1920*

20 UNDERTAKER

ADDRESS

*Philip Herwig**2016 Orleans St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact Statement of UPA- TION is very important. See instructions on back of certificates.

MAY 18 1920

D43263

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43263

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital* ST. *8* WARD.)2-FULL NAME *Thomas B. Hoddinott*(a) RESIDENCE. NO. *1431 N. Bond* ST. *2* WARD. *2*

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. mos. ds.How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Louise Hoddinott*6 DATE OF BIRTH (month, day, and year) *Aug. 1855*

7 AGE

Years *65*Months *9*Days *—*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Wheel-Wright*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto. Co.*10 NAME OF FATHER *James Hoddinott*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto. Co.*12 MAIDEN NAME OF MOTHER *Elizabeth Christopher*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto. Co.*

14

Informant (Address) *Ralph T. Hoddinott*

MAY 18 1920

REG. 13 41102 DEPT. H

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 17 1920*

17

I HEREBY CERTIFY, That I attended deceased from *May 14*, 19 *20*, to *May 17*, 19 *20*, that I last saw him alive on *May 17*, 19 *20*, and that death occurred, on the date stated above, at *11:15 P.* m.

The CAUSE OF DEATH* was as follows:

*Cerebral haemorrhage (Apoplexy)*CONTRIBUTORY (Secondary) *Chronic interstitial nephritis* (duration) *3* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical signs*(Signed) *J. B. Bronushas* M. D.F. 17, 19 *20* Address) *St Joseph's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cathedral Cemetery**5/20* 19 *20*

20 UNDERTAKER

ADDRESS

Chas E. Evans, Son, 118 N. Mt Royal Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43264

D43264

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 W. Monument ST.; 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edwin H. Smith

(a) RESIDENCE. NO.

218 W. Monument ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

20 yrs.

mos.

ds.

How long in U. S., if of foreign birth

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1861-6-9

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

68117

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Salisbury Maryland

10 NAME OF FATHER

Thomas B. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Salisbury Maryland

12 MAIDEN NAME OF MOTHER

Margaret E. Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Mrs. Wilbur H. Jackson
218 W. Monument St.

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 16, 1920

17

I HEREBY CERTIFY, That I attended deceased from

May, 1919, to May 16, 1920,that I last saw him alive on May 16, 1920,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Ulcer of Stomach(duration) one yrs. one mos. one ds.

CONTRIBUTORY (Secondary)

age gastritis

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wilbur P. Morgan, M. D., 19 (Address) 315 W. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park5-19 1920

20 UNDERTAKER

ADDRESS

Henry W. Jenkins Sons Co.W. G. Guller
Orchard

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Fact Statement OCCUPATION is very important. See instructions on back of certificates.

MAY 18 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43265

D43265

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *6064 Montford Ave* ST.; *7* WARD)

REGISTERED NO. C

2-FULL NAME

William Joseph Ellis

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *6064 N. Montford Ave* St.; *2* yrs., *2* mos., *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

March 2, 1920
(Month) (Day) (Year)

7-AGE,

*2 yrs., 2 mos., 15 ds.*IF LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),*Baltimore Md*

PARENTS.

10-NAME OF FATHER,

*George Ellis*11-BIRTHPLACE OF FATHER
(State or Country),*Md.*

12-MAIDEN NAME OF MOTHER

*Marie Schuler*13-BIRTHPLACE OF MOTHER
(State or Country),*Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George Ellis*(Address) *6064 N. Montford Ave*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 17, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 8, 1920, to May 17, 1920,*that I saw him alive on *May 17, 1920,*and that death occurred, on the date stated above, at *7 p. m.*

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY...*(Symptoms of Congenital Lesions)*.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Frank J. Ayer* M. D.*May 17, 1920* (Address) *2065 E. Monument St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Church

DATE OF BURIAL,

May 18, 1920

20-UNDERTAKER

Herb L. Miller

ADDRESS

2837 Jaffan

MAY 18 1920

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. See instructions on back of certificate.

D43266

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43266

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2357 Rose ST.: 6 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 2357 Rose

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

ST.

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? 66 yrs. 1 mos. 8 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

(or) WIFE of

Emma V. Holland

6 DATE OF BIRTH (month, day, and year)

May 9 1854

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

668

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 17 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 18 1919, to May 17 1920, that I last saw him live on May 17 1920, and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Gravitus MellitusCONTRIBUTORY (Secondary) Diabetes Coma (duration) 2 yrs. 2 mos. 2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Leover, M. D.Address 413 17th Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Lawn CemeteryMay 20 1920

20 UNDERTAKER

ADDRESS

Mrs. C. Miller2834 Jefferson

Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 18 1920

D43267

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43267

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1209 Winchester St. 16 WARD)

2-FULL NAME Baby Morris

(Residence in Baltimore: No. 1209 Winchester St.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, black 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 15, 1920 (Month) (Day) (Year)

7-AGE, If LESS than 1 day, 15 hrs. or more? 15 hrs. or more?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, none (b) General nature of industry, business, or establishment in which employed (or employer), 000

9-BIRTHPLACE, (State or Country), Balt. Md.

10-NAME OF FATHER, Elliott Morris

11-BIRTHPLACE OF FATHER, (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Annis Rich

13-BIRTHPLACE OF MOTHER, (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-MAY 18 1920 Robert P. Harrison, 101

Burial Permit 1212

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 15, 1920 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, (Inquest, au-

guiry, And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patent foramen

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Harrison M. D.

(Coroner.)

May 16, 1920 (Address) 2802 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Johns Hopkins Hospital May 18 1920

20-UNDERTAKER, Address

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43268

D43268

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 Roland Ave

ST.; 27th WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Ella Stuart Gibson

(Residence in Baltimore: No. 105 Roland Ave

St.; — yrs., 5 mos., 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH.

June 12, 1864
(Month) (Day) (Year)

7-AGE,

55 yrs., 11 mos., 6 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer).

068

9-BIRTHPLACE,

(State or Country),

Winchester Va

PARENTS.

10-NAME OF FATHER,

Bruce Gibson

11-BIRTHPLACE OF FATHER

(State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Mary E. Russell

13-BIRTHPLACE OF MOTHER

(State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

A. L. Green

(Address)

Winchester Va.

15-

Robert P. Harrison,

MAY 18 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 18, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15, 1920, to May 18, 1920, that I saw her alive on May 18, 1920, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Right Hemiplegia
(Duration) 3 yrs., 3 mos., 3 ds.

CONTRIBUTORY (Secondary)

arterio-sclerotic
(Duration) 3 yrs., 3 mos., 3 ds.

(Signed)

M. G. Porter M. D.

May 18, 1920 (Address) 422 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Winchester Va.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Winchester Va.

May 19, 1920

STEWART & HOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43269.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43269

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 E Chase ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry P. Donlan(a) RESIDENCE. No. 1003 E Chase ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16 18617 AGE Years 59 Months 1 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman(b) General nature of industry, business, or establishment in which employed (or employer) City Engineer's Department

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Anthony Donlan11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)12 MAIDEN NAME OF MOTHER Rose O'Brien13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)14 Informant Mrs. Margaret Donlan (Address) 1003 E Chase St

15 Robert P. Harrison, Registrar

MAY 18 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 192017 I HEREBY CERTIFY, That I attended deceased from 5-12, 1920, to 5-17, 1920, that I last saw him alive on 5-13, 1920, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) ? yrs. mos. da.

CONTRIBUTORY arteriosclerosis (Secondary) (duration) Small yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? none (Signed) Dr. Bernard W. ... M. D.J.H. 1920 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Vincent Cemetery May 18 1920

20 UNDERTAKER ADDRESS

Edmund W. Conklin 124 E Eager

Physician should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of physician is very important. See instructions on back of certificates.

D43270

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43270

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George O'Malley(a) RESIDENCE. No. Unknown

(Usual place of abode)

ST.

WARD. Cleveland O.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos.ds. How long in U. S., if of foreign birth? yrs. 2 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown6 DATE OF BIRTH (month, day, and year) 18 56

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
64				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cleveland, Ohio
(State or country)10 NAME OF FATHER John O'Malley11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14

Informant Hospital Records
(Address) New City Hospital.

15

Filed Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17, 1920

17

I HEREBY CERTIFY, That I attended deceased from
February 28, 1920, to May 17, 1920.
that I last saw him alive on May 16, 1920.
and that death occurred, on the date stated above, at 7:00 A. m.

The CAUSE OF DEATH* was as follows:

Hypernephrosis(duration) 2 yrs. mos. ds.CONTRIBUTORY Fracture RV. hip
(Secondary)(duration) 6 yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. P. Pessel

M. D.

May 17 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St VincentsMay 19 1920

20 UNDERTAKER

E. A. Wudfeldt

DECEASED

Summit

MAY 18 1920

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DEATH should be stated in plain terms. See instructions on back of certificates.

D43271

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43271

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1118 hantecoh*)

ST.: *21* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thomas Wilkins

(a) RESIDENCE. No. *1118 hantecoh*
(Usual place of abode)

ST.: *21* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *26* yrs. *1* mos. *29* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Parish A. Wilkins

6 DATE OF BIRTH (month, day, and year) *March 17th 1834*

7 AGE Years *86* Months *1* Days *29* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

home 880

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Va.*
(State or country)

10 NAME OF FATHER *Unknown*

11 BIRTHPLACE OF FATHER (city or town) *Unknown*
(State or country)

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) *Unknown*
(State or country)

14 Informant *Dr. H. Wilkins*
(Address) *Robert P. Hamilton*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 16 1920*

17 I HEREBY CERTIFY, That I attended deceased from *April 10*, 1920, to *May 16*, 1920, that I last saw him alive on *May 16*, 1920, and that death occurred, on the date stated above, at *5-8* m. The CAUSE OF DEATH* was as follows:

Senile Decay

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Supp. Aorta* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Edmund Sample*, M. D.

17. 1920 (Address) *517 Hollor*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mount Olivet Cem *May 19 1920*

20 UNDERTAKER ADDRESS *517 Hollor*

E. Schloman & Son *Hannover*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 18 1920 Burial Permit Clerk Registrar

D43272

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43272

CERTIFICATE OF DEATH.

REGISTERED NO. C.

PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Joseph Hospital* ST. *23* WARD)FULL NAME *John Charles Bush*(Residence in Baltimore: No. *932 Honover*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Boy*
(Write the word)6-DATE OF BIRTH, *1*
(Month) (Day) (Year)7-AGE, *8*
yrs. mos. ds.If LESS than 1 day,
hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Boy School*9-BIRTHPLACE, (State or Country), *Balto.*10-NAME OF FATHER, *John L. Bush*11-BIRTHPLACE OF FATHER (State or Country), *Balto*12-MAIDEN NAME OF MOTHER, *Alvina (mailed)*13-BIRTHPLACE OF MOTHER (State or Country), *Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John L. Bush*(Address) *932 Honover*

15-

Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 17*, 19*20*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)Thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.)I find that said deceased came to death *on the day stated above.* (topsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Traumatic fall off wagon while driving on road (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Wm. J. Ingham*

(Coroner.)

5-18-20 (Address) *11 E. 1st*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Oak Lawn Cem.*DATE OF BURIAL, *May 19*, 19*20*20-UNDERTAKER, *F.A. Francis & Son*ADDRESS, *1039 Hanover St*

MAY 18 1920 Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43273

D43273

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1836 Belt Ave ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Wesley Winks.

(a) RESIDENCE. No.

1836 Belt Ave ST. 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Don't know.

6 DATE OF BIRTH (month, day, and year)

Don't know

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

abt 74

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Halvers 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto - Md.

10 NAME OF FATHER

Don't know.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Margaret E. ThompsonRobert E. Harrison,

Registrar

MAY 18 1920

Filed 19

Dr. White - 1279 W. 1st St. 7th floor

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17- 1920.

17

I HEREBY CERTIFY, that I attended deceased from

April 1, 1920, to May 17, 1920.that I last saw him alive on May 16, 1920.and that death occurred, on the date stated above, at 11.35 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx.(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? none

(Signed)

C. M. White

M. D.

Address) 1279 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western

DATE OF BURIAL

May 19- 1920

20 UNDERTAKER

William Cook

ADDRESS

503 S. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43274 HEALTH DEPARTMENT—CITY OF BALTIMORE

D43274

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

404 S. Calhoun

ST.: 19

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Blanche E. Wideman
also known as Blanche Wilhelm

(a) RESIDENCE. NO.

404 S. Calhoun

ST..

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

37 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Walter Wilhelm. from whom she lived apart. Nov 30 - 1893

6 DATE OF BIRTH (month, day, and year)

Nov 30 - 1893

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

46

5

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

037

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Marion Francis Wideman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Co., Md.

12 MAIDEN NAME OF MOTHER

Mary Boysen

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md.

14

Informant
(Address)

Mrs Mary Smith
404 S. Calhoun St.

15

Filed

Robert V. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 17 - 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 13, 1918 to May 17, 1920.

that I last saw her alive on May 15, 1920.

and that death occurred, on the date stated above, at 12-10 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Over 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Roentgen Ex by Dr. Henry E. ... M. D.

(Address) 1203 W. Fayette St.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

DATE OF BURIAL

May 19 - 1920

20 UNDERTAKER

William Cook

ADDRESS

503 E. North

Burial Permit Clerk

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D43273

CERTIFICATE OF DEATH

D43273

1-PLACE OF DEATH *Baltimore, Maryland*

REGISTERED NO. C

CITY OF BALTIMORE (No. *311 E. Lafayette Ave*)

ST. *12* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Sidney L. Mumford*

(Residence in Baltimore: No. *311 E. Lafayette Ave*)

Sr. *Lif* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *married* (Write the word)

6-DATE OF BIRTH *January 25, 1871* (Month) (Day) (Year)

7-AGE *49* yrs. *3* mos. *22* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION *Linotype Operator* (a) Trade, profession, or particular kind of work *Job Printer* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) *Maryland*

10-NAME OF FATHER *Eugene Mumford*

11-BIRTHPLACE OF FATHER (State or country) *Maryland*

12-MAIDEN NAME OF MOTHER *Mary Merritt*

13-BIRTHPLACE OF MOTHER (State or country) *Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Tilley Mumford* (Address) *311 E. Lafayette Ave*

15-*Robert P. Harrison,*

MAY 18 1920 *191* *Permit Clerk* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 17, 1920* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 13, 1920*, to *May 17, 1920*, that I saw him alive on *May 16, 1920*, and that death occurred, on the date stated above, at *10:30 A.M.* The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) *unknown* yrs. mos. ds.

Contributory (SECONDARY) *none*

(Signed) *Marke L. Ingram* M. D. *May 17, 1920* (Address) *2439 N. Charles*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State *2* yrs. mos. ds.

Where was disease contracted, If not at place of death? *unknown*

Former or usual residence *311 E. Lafayette Ave*

19-PLACE OF BURIAL OR REMOVAL *Baltimore* DATE OF BURIAL *May 19, 1920*

20-UNDERTAKER *William Cook* ADDRESS *502 E. North Ave.*

Spec.—6-9-19—H. P. Co.—1000 Bks.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43276

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43276

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Baltimore - Mt Hope Retreat* ST. *28th* WARD)

2-FULL NAME

Margaret Carlin

(a) RESIDENCE. No. *Mt Hope Retreat* ST. *28th* WARD.

(Usual place of abode) Length of residence in city or town where death occurred *6* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*

6 DATE OF BIRTH (month, day, and year) *July 18, 1868*

7 AGE Years *51* Months *10* Days *0* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)

10 NAME OF FATHER *Frank Carlin*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *Maryland*

12 MAIDEN NAME OF MOTHER *Mary Deane*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *Maryland*

14 Informant *Records of Mt Hope Retreat* (Address) *Mt Hope Retreat, Baltimore* *Robert T. Harrison,*

MAY 18 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 18th* 19 *20*

17 I HEREBY CERTIFY, That I attended deceased from *Sept 30-1914*, 19, to *May 18th*, 19 *20*, that I last saw her alive on *May 17th*, 19 *20*, and that death occurred, on the date stated above, at *7.15 A.* m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

abs (duration) *0* yrs. *1* mos. *0* ds. CONTRIBUTORY *Chronic Recurrent Mania* (Secondary) *abs* (duration) *10* yrs. *0* mos. *0* ds.

18 Where was disease contracted *Baltimore Md* if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Frank J. Flannery* M. D. *May 18, 1920* (Address) *Mt Hope Retreat Baltimore*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cern

DATE OF BURIAL

May 20, 1920

20 UNDERTAKER

Harry W. Ehlen

ADDRESS

W. North Ave

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43272

HEALTH DEPARTMENT--CITY OF BALTIMORE

D43272

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

4253 Park Heights Ave

WARD

2-FULL NAME

Engenia Finley

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

4253 Park Heights Ave

Sr. 58 yrs. 5 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

December 9, 1861

7-AGE

58 yrs. 5 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None 037

9-BIRTHPLACE

(State or country)

Baltimore Md

10-NAME OF FATHER

Edward R. Hemmick

11-BIRTHPLACE OF FATHER

(State or country)

Baltimore Md

12-MAIDEN NAME OF MOTHER

Sarah Auster

13-BIRTHPLACE OF MOTHER

(State or country)

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Finley

(Address)

4253 Park Heights Ave

15.

Robert P. Harrison,

MAY 18 1920

Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 17th, 1920

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 1917, to May 17th 1920

that I saw her alive on May 16th 1920

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with Cardiac dilation

Has not been in good health for several yrs.

Contributory

(SECONDARY)

Pulmonary edema

(Signed) J. H. Lay M. D.

May 18, 1920 (Address) 1028 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

May 20, 1920

20-UNDERTAKER

Geo W Little

ADDRESS

5314 Diamond Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43278

CERTIFICATE OF DEATH.

120

D43278

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>male</i>	4-COLOR OR RACE, <i>black</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, <i>married</i> (Write the word.)
6-DATE OF BIRTH, <i>March 27, 1854</i> (Month) (Day) (Year)		
7-AGE, <i>66</i> yrs., <i>1</i> mos., <i>19</i> ds.		If LESS than 1 day, ...hrs. or ...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work, <i>Retired minister</i> (b) General nature of industry, business, or establishment in which employed (or employer), <i>018</i>		
9-BIRTHPLACE, (State or Country), <i>North Carolina</i>		
PARENTS.	10-NAME OF FATHER, <i>Isaac Henry</i>	
	11-BIRTHPLACE OF FATHER, (State or Country), <i>North Carolina</i>	
	12-MAIDEN NAME OF MOTHER, <i>unknown</i>	
	13-BIRTHPLACE OF MOTHER, (State or Country), <i>North Carolina</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

MAY 19 1920

ROBERT E. KRAUTER

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 16, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*
(Inquest, au-

inquest find that said deceased came to death
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Ischemic Heart Disease

(Duration) *1* yrs. *6* mos. *19* ds.

CONTRIBUTORY
(Secondary)

(Duration) *3* yrs. *6* mos. *19* ds.

(Signed) *J. H. Harrison* M. D.
(Coroner.)

May 17, 1920 (Address) *2802 Edmondson Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,

Mount Auburn

DATE OF BURIAL,

May 19, 1920

20-UNDERTAKER

John R. Owens

ADDRESS

538 Ralph St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43279

CERTIFICATE OF DEATH.

28

D43279

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 537 Oxford. ST.: 17 WARD)

2-FULL NAME John M. Simmonds

(a) RESIDENCE. No. 537 Oxford. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Coburn 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Oscar C. R. Simmonds

6 DATE OF BIRTH (month, day, and year) Feb 1885

7 AGE Years 35 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER Turner Newman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Cuba

12 MAIDEN NAME OF MOTHER Marie Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

La

14 Informant Maria Newman (Address) 537 Oxford St.

15 MAY 19 1920 ROBERT E. KRAUTER

Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/16 19 20

17 I HEREBY CERTIFY, That I attended deceased from April 26, 19 20, to May 16, 19 20, that I last saw him alive on May 15, 19 20, and that death occurred, on the date stated above, at 11:55 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Intercuriosis

(duration) yrs. 6 mos. ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) David Granclien, M. D.

5/17 19 20 (Address) 172 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Int. Zim

May 19 1920

20 UNDERTAKER

ADDRESS 142

John H. Toadine

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43280

CERTIFICATE OF DEATH.

92 D43280

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *921 E. Hoffman* ST.: *9* WARD)2-FULL NAME *Edward Logue*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. *921 E. Hoffman* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April 29-1919*7 AGE Years *1* Months *0* Days *19* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *James C. Logue*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *Agnes McEvoy*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*14 Informant *Agnes Logue* (Address) *921 E. Hoffman*15 *MAY 19 1920* *ROBERT H. KRAUTER* Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 18* 19 *20*17 I HEREBY CERTIFY, That I attended deceased from *May 17*, 19 *20*, to *May 18*, 19 *20*, that I last saw him alive on *May 17*, 19 *20*, and that death occurred, on the date stated above, at *7 a*. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(duration) yrs. mos. *5* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? *Home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical test*(Signed) *Wm. Brown*, M. D.May 19 1920 Address) *5 Preston St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral *May 19* 19 *20*

20 UNDERTAKER

ADDRESS

H. C. Wiedefeld *914*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43281

D43281

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 Fountain ST.; 79 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Mr Bond

(a) RESIDENCE. NO.

2000 Fountain

ST., 2 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 8 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Oct 2, 1904

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

15

8

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

A one attendant

(b) General nature of industry, business, or establishment in which employed (or employer)

at school. 000

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md

10 NAME OF FATHER

William Mr Bond

11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Therese Diddley

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

Md.

14

Informant

Wm H. McCord

(Address)

2000 Fountain St.

15

Filed

19

MAY 19 1920

ROBERT E. KRAUTER

Registrar

Baptist Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-16

1920

17

I HEREBY CERTIFY, That I attended deceased from

April 1st, 1920, to April 16, 1920,

that I last saw him alive on April 15, 1920,

and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia & broken

compensation

(duration) yrs. mos. 16 ds.

CONTRIBUTORY

Broncho Pneumonia

(Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Signs & symptoms

(Signed)

Wm H. McCord

M. D.

, 1920 (Address)

1623 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Carmel Cem

May 19 1920

20 UNDERTAKER

ADDRESS

Lilly & Zeller

400 S. Hope St.

Physicians should state EXACTLY. Exact statement should be properly classified. See instructions on back of certificates.

D43282

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43282

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1339 N Patterson Pl ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1339 N P. Pl ST. 8 WARD. (If nonresident give city or town and State)Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
5a If married, widowed, or divorced HUSBAND of (or) WIFE of		

6 DATE OF BIRTH (month, day, and year) Nov 8, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<u>29</u>	<u>6</u>	<u>9</u>	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work
Clerk. 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Balto Md

10 NAME OF FATHER

John H. Vieira
Balto Md11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

Katherine Stephens
Balto Md13 BIRTHPLACE OF MOTHER (city or town)
(State or country)14 Informant Katherine Stephens
(Address) 1339 N P. Pl15 MAY 19 1920 ROBERT E. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1920

17 I HEREBY CERTIFY, That I attended deceased from
April 20 — 1920, to May 16, 1920,
that I last saw him alive on May 16, 1920,
and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) 1 yrs. — mos. — ds.CONTRIBUTORY
(Secondary)(duration) 1 yrs. 1 mos. — ds.18 Where was disease contracted
if not at place of death? CityDid an operation precede death? No Date of —Was there an autopsy? noWhat test confirmed diagnosis? —(Signed) Wm. H. Henshaw M. D.19 (Address) 125 S. Potomac

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Balto Cem

DATE OF BURIAL

May 19 1920

20 UNDERTAKER

J. Herwig & Co

ADDRESS

2008 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43284

D43284

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2319 Guilford Ave. ST. 17 WARD)

REGISTERED No. C _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oliver K. Barrett(Residence in Baltimore: No. 2319 Guilford Ave. St.; 17 yrs., _____ mos., _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male4-COLOR OR RACE, White5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH, June 2, 1861

(Month)

(Day)

(Year)

7-AGE, 58 yrs., 11 mos., 15 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Train Dispatcher(b) General nature of industry, business, or establishment in which employed (or employer), Pa. Railroad9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Oliver K. Barrett11-BIRTHPLACE OF FATHER (State or Country), Maryland12-MAIDEN NAME OF MOTHER, Sarah Beatty13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Caroline Barrett(Address) 2319 Guilford Ave.

15-

MAY 19 1920

191

ROBERT E. KRAUTER

BRIEF STATEMENT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from May 16, 1920, to May 17, 1920,that I saw him alive on May 17, 1920and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Wm. J. Kratz M. D.May 18, 1920 (Address) 712 E. St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cork PaDATE OF BURIAL, May 20, 192020-UNDERTAKER, A. S. MarshallADDRESS, 3089 Fall Road

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43285

CERTIFICATE OF DEATH.

92 D43285

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 Carwell Ave.,

ST.; 13 WARD)

2-FULL NAME Dorathy A. Fisher

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 702 Carwell Ave.,

St.; 13 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
4-COLOR OR RACE, "hite"
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, January 16, 1915, 1
(Month) (Day) (Year)

7-AGE, 5 yrs. 3 mos. 13 ds.
If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore City

10-NAME OF FATHER, James H. Fisher

11-BIRTHPLACE OF FATHER, Maryland
(State or Country),

12-MAIDEN NAME OF MOTHER, Ellen B. Cronbwer

13-BIRTHPLACE OF MOTHER, Maryland
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

James H. Fisher

(Informant).....

(Address) 702 Carwell Ave.

MAY 19 1920

ROBERT E. KRAUTER

Filed..... 191.....

Burial in the City of Baltimore

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 18, 1920, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 13, 1920, to May 18, 1920, 191...

that I saw her alive on May 18, 1920, 191...

and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration)..... yrs..... mos. 6 ds.

CONTRIBUTORY..... (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) A. J. Davies M. D.

May 18, 1920, 191... (Address) 800 W. 33rd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Marys Hospital May 20 1920

20-UNDERTAKER, ADDRESS

Chenoweth Son Chestnut St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43287

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.;

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

33

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

037

9-BIRTHPLACE, (State or Country),

Russia

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J. Lewis
1411 E. Baltimore St.

15-

MAY 19 1920

ROBERT S. KAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 19

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 18 1920, to May 19 1920

that I saw her alive on May 19 1920

and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary Edema

(Duration) yrs. mos. ds.

(Signed) Harry Goodman, M.D.

May 19 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State 11 yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 133 S. Spring St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew Rosedale

May 19 1920

20-UNDERTAKER

ADDRESS

Jack Lewis

1411 E. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

43288

D43288

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 712 W. Hamburg

ST. 21 WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret M. Weiner

(Residence in Baltimore: No. 712 W. Hamburg

St. 21 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Mar 10, 1906 (Month) (Day) (Year)

7-AGE, 14 yrs. 2 mos. 8 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, none (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

10-NAME OF FATHER, Henry Weiner

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Elizabeth Marshall

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Weiner (Father)

(Address) 712 W. Hamburg St.

15-

MAY 19 1920

ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 18, 1920 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from 1919, to May 18, 1920, that I saw her alive on May 18, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about 3 yrs. mos. ds.

CONTRIBUTORY Pulmonary oedema (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. E. Knapp M. D.

May 18, 1920 (Address) 1002 W. Fairview

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Western Cemetery May 21, 1920

20-UNDERTAKER, ADDRESS

James D. Gorman, 1002 W. Fairview

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43289

CERTIFICATE OF DEATH.

170 D43289

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 E. Preston ST.; 10 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 912 E Preston St.; 5 yrs., 2 mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-~~MARRIED~~ Married
OR ~~DIVORCED~~
(Write the word.)

6-DATE OF BIRTH,

June 15, 1866
(Month) (Day) (Year)

7-AGE,

53 yrs., 11 mos., 4 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Housewife
0379-BIRTHPLACE,
(State or Country),York County, Penna

10-NAME OF FATHER,

Henry Strickles11-BIRTHPLACE OF FATHER
(State or Country),York County Penna

12-MAIDEN NAME OF MOTHER

Sarah Bowman13-BIRTHPLACE OF MOTHER
(State or Country),York County-Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Ilgenfritz(Address) 912 E. Preston St.

15-

MAY 19 1920Filed..... 191..... ROBERT F. LAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 19, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from March 5 1919, to May 19 1920, that I saw h. er alive on May 18 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial
Nephritis(Duration) 1 yrs., 2 mos., 14 ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. J. Daves M. D.5/19, 1920 (Address) 800 W 33rd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

York York Co Pa May 19, 1920

20-UNDERTAKER

ADDRESS

Wm Coats 5026 York

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Go. Geo. Ilgenfritz. Via N.C. R.R.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43290

D43290

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* ST.: *4* WARD)2-FULL NAME *Mrs. Constance Waller*(a) RESIDENCE. NO. *Mrs. Waller* ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Negro

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Priscilla Waller*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Records, Mary Hospital

15

Filed

MAY 19 1920

ROBERT E. KRAUTER Registrar

Baltimore Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5, 18* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

May 2, 1920 to *May 18, 1920*that I last saw him alive on *May 18, 1920*and that death occurred, on the date stated above, at *4:20* m.

The CAUSE OF DEATH* was as follows:

Myocardial

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Lucius D. B. B. B.* M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Lamar Cemetery**May 19 1920*

20 UNDERTAKER

ADDRESS

Edwin R. B. B. B.

N. B.—WRITE CAREFULLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

D43291

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43291

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 N. Carey St.

ST. 19

WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith L. Bowers

(a) RESIDENCE. No. 6 N. Carey St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

4

mos.

1

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 17, 1920.

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

4

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Charles E. Bowers

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Doran

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Maryland.

14

Informant
(Address)Mrs. Charles Bowers
6 N. Carey St.

15

MAY 19 1920

ROBERT E. REAULT
Registrar

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 17, 1920, to May 18, 1920.

that I last saw her alive on May 17, 1920.

and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Bacterial Pneumonia

(duration) yrs. mos. 20 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. H. B. Hubert, M. D.

, 19 (Address) 1100 W. Lof. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Funeral Home

May 20 1920

20 UNDERTAKER

Joseph B. Cook

ADDRESS

1603 N. Balt. St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43292

CERTIFICATE OF DEATH.

REGISTERED NO.

D43292

1-PLACE OF DEATH

(nursing Home)

CITY OF BALTIMORE: (No. 723 St. Paul -

ST.:

WARD)

2-FULL NAME

Mr. ~~Clinton~~ C. Walker -

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

Albion Hotel -

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

10

yrs.

--

mos.

--

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE 55 Years -- Months -- Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Auto Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Co.,
(State or country) Maryland

10 NAME OF FATHER Patrick Henry Walker

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rosa B. Mittnacht

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Maryland

14 Informant Henry M. Walker

(Address) 2927 N. Calvert Street

15 MAY 19 1920

ROBERT B. ELSTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 17 1920

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 28

1920, to

Apr. 17, 1920.

that I last saw him alive on 5/17, 1920.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Disease
Pulmonary edema
Cardiac failure

(duration) 1 yrs. 3 mos. -- ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Leslie N. Gay, M. D.

19 (Address) 1107 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Green Mount Cemetery

5/19 1920

20 UNDERTAKER

ADDRESS

Henry W. Mears & Son 805 N. Calvert

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43293

CERTIFICATE OF DEATH.

REGISTERED NO. C

D43293

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2400 Allendale Rd. St.; 15 WARD)2-FULL NAME Henry W. Crass(Residence in Baltimore: No. 2400 Allendale Rd. St.; 32 yrs., 3 mos., 1 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male4-COLOR OR RACE, White5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, Aug 29 1857

(Month)

(Day)

(Year)

7-AGE, 82 yrs., 8 mos., 19 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer) None9-BIRTHPLACE, (State or Country), Germany10-NAME OF FATHER, H. Crass11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER Not known13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. (Theobald)(Address) 2400 Allendale Rd.

MAY 19 1920

ROBERT B. KRAUTER

Filed....., 191.....

Burial Place Registered

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 18, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from May 16 1920, to May 18 1920,that I saw him alive on May 16 1920,and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis
myocarditis
apoplexy Chronic pyelonephritis
nephritis (Duration)..... yrs..... mos..... ds.CONTRIBUTORY pyelonephritis, nephritis
(Secondary) myocarditis (Duration)..... yrs..... mos..... ds.(Signed) J. S. Mublett M. D.May 18, 1920 (Address) 3412 Elyton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the..... yrs..... mos..... ds. State.....

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Matthews Cem.DATE OF BURIAL, May 21 192020-UNDERTAKER, Philip HerwigADDRESS 2016 Orleans St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43294

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 Madison Ave.,

ST.: 14 WARD)

2-FULL NAME Rev. Tobias Salzman,

(a) RESIDENCE. NO. 1609 Madison Ave.,

ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male,

4 COLOR OR RACE

White,

5 Single, Married, Widowed,
or Divorced (write the word)
Widower,

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Frederick Salzman,

6 DATE OF BIRTH (month, day, and year) Mch. 15th. 1847.

7 AGE

Years

Months

Days

73

2

3

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Minister, D18

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Russia,

10 NAME OF FATHER Unknown,

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia,

12 MAIDEN NAME OF MOTHER

Unknown,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia,

14

Informant J. Salzman,

(Address)

1609 Mad. Ave.,

15 Filed MAY 19 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18th. 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 1, 1920 to May 18, 1920.

that I last saw him alive on May 18, 1920.

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 4 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) 3 yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theo. H. Morrison, M. D.

, 19 (Address) 1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Hebrew Friendship,

DATE OF BURIAL

May 20 1920

20 UNDERTAKEN

David Dondheim

ADDRESS

48 W. 4th St.

Information should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. EXAMINER should state OCCUPATION is very important. See instructions on back of certificates.

Information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Specs.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43295

CERTIFICATE OF DEATH.

120 D43295

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2816 N. North Ave. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

d.

WARD.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 15 1883

7 AGE Years 87 Months 1 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant (Address)

15

MAY 19 1920

Robert P. Harrison Registrar

Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1920

17 I HEREBY CERTIFY, That I attended deceased from May 10th 1920, to May 18th 1920, that I last saw her alive on May 18th 1920, and that death occurred, on the date stated above, at 3.30 P. M. The CAUSE OF DEATH* was as follows:

Ph. Carcinoma of the lungs
repeating
(duration) 2 yrs. mos. ds.
CONTRIBUTORY Ph. Leukemia of the blood
(Secondary) (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & chemical
(Signed) Geo. H. J. Lauterbach, M.D.

5-18, 1920 Address) 2215 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Hebrew Burial Society May 20 1920

20 UNDERTAKER ADDRESS

David Sander 1184 N. York St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43296

D43296

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2838 Parkwood ST.; 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J. Kolb(Residence in Baltimore: No. 2838 Parkwood St.; 60 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow6-DATE OF BIRTH, Feb., 1831
(Month) (Day) (Year)7-AGE, 89 yrs., 3 mos., 0 ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, none
(b) General nature of industry, business, or establishment in which employed (or employer), 0009-BIRTHPLACE, (State or Country), Virginia10-NAME OF FATHER, Not known11-BIRTHPLACE OF FATHER (State or Country), Va.12-MAIDEN NAME OF MOTHER Eliza Stern13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. B. Bowen(Address) 2838 Parkwood15- Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May, 19, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 19 1920, to May 14 1920, that I saw h. alive on May 18 1920, and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Senile Debility

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY Myocardial
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) John A. Carey, M. D......, 191... (Address) 101 N. Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery DATE OF BURIAL, May 19, 192020-UNDERTAKER Ed. Manning & Son ADDRESS 138 E. Lafayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 19 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

043297

D43297

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *536 N. Castle* ST.: *7* WARD *7*)

2-FULL NAME

(Residence in Baltimore: No. *536 N. Castle* St.: *7* yrs., *0* mos., *0* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

February 25, 1919
(Month) (Day) (Year)

7-AGE,

1 3
yrs. mos. ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....*None*
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....*000*9-BIRTHPLACE,
(State or Country),*Roanoke Va.*10-NAME OF
FATHER,*S.R. Hiner*11-BIRTHPLACE
OF FATHER
(State or Country),*Roanoke Va.*12-MAIDEN NAME
OF MOTHER*Andelia Falls*13-BIRTHPLACE
OF MOTHER
(State or Country),*Roanoke Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*S.R. Hiner*(Address).....*536 N. Castle St.*

15-

*Robert P. Harrison,**191*

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 5, 1920, to May 14, 1920,*that I saw her alive on *May 14, 1920,*and that death occurred, on the date stated above, at *8 A. m.*

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....*Frank J. Ayer*.....M. D.*May 19, 1920* (Address).....*2065 E. Monument St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence*Roanoke Va.*

19-PLACE OF BURIAL OR REMOVAL,

Roanoke Va.

DATE OF BURIAL,

MAY 19 1920

20-UNDERTAKER

Cro. M. Fink & Son,

ADDRESS

811 N. Wolfe

Funeral Directors & Embalmers.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 19 1920

D43298

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Nursery & Childs Hospital* St.; *18* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Nursery & Childs Hospital* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Infant*

6-DATE OF BIRTH, *August 10, 1919*
(Month) (Day) (Year)

7-AGE, *9 yrs. 9 mos. 9 ds.* If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer). *ood*

9-BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *Robt. Bennington*

11-BIRTHPLACE OF FATHER (State or Country), *md.*

12-MAIDEN NAME OF MOTHER *Myrtle pierce*

13-BIRTHPLACE OF MOTHER (State or Country), *md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles K. Harrison*

(Address) *1000 H. Fayette St.*

15-

MAY 19 1920 Robert P. Harrison,
191.....

Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 19, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 10, 1920*, to *May 19, 1920*, that I saw her alive on *May 19, 1920*, and that death occurred, on the date stated above, at *6 A.* m. The CAUSE OF DEATH* was as follows:

Measles
(Duration).....yrs.....mos.....7.....ds.

CONTRIBUTORY...*Bronch. pneumonia*
(Secondary)

(Signed) *L. J. Fairclough* M. D.
5/19/20 (Address) *2002 E. Pratt St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? *at place of death*

Former or usual residence *md.*

19-PLACE OF BURIAL OR REMOVAL, *London Park*

DATE OF BURIAL, *May 21, 1920*

20-UNDERTAKER *Geo J. Smith*

ADDRESS *Fayette St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43299

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43299

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 Crestview ST.: 15 WARD)

2-FULL NAME Thomas James Randall

(a) RESIDENCE. NO. 1504 Crestview ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE 43 Years Months Days If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hunter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind (State or country)

10 NAME OF FATHER Edward Randall

11 BIRTHPLACE OF FATHER (city or town) Ind (State or country)

12 MAIDEN NAME OF MOTHER Mahalia Burgess

13 BIRTHPLACE OF MOTHER (city or town) Ind (State or country)

14 Informant Mrs. Mahalia Randall (Address) 1504 Crestview St.

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18th 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb 3rd, 1920, to May 18th, 1920,

that I last saw him alive on May 18th, 1920, and that death occurred, on the date stated above, at 9.00 P. m.

The CAUSE OF DEATH* was as follows:

Intercostal Neuritis
followed by
Cerebral Apoplexy
(duration) yrs. 3 mos. 15 ds.

CONTRIBUTORY Exhaustion (Secondary) (duration) yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical
(Signed) Geo. H. Foxworth M. D.

(Address) 5215 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Peter May 25th

20 UNDERTAKER ADDRESS

Samuel Wright 364 N. Mary

MAY 19 1920

Burial Permit Clerk.

D43300

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43300

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 Bank

ST.;

WARD) 2

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Clementine Gaglewski)(a) RESIDENCE. NO. 1908 Bank

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

FemalewhiteBaby5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

19 Nov 1918

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.16—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore

10 NAME OF FATHER

John Gaglewski11 BIRTHPLACE OF FATHER (city or town)
(State or country)Poland

12 MAIDEN NAME OF MOTHER

Francis Madolny13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Baltimore

14

Informant
(Address)Peter Madolny
1908 Bank

15

Filed

Robert P. Harrison,

Registrar

MAY 19 1920

Burial permit clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-19 1920

17

I HEREBY CERTIFY, That I attended deceased from

5-18, 1919, to 5-18, 1920,that I last saw her alive on 5-18, 1920.and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Surgical Department

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Examination(Signed) Harry A. Phillips M. D.1920 (Address) 1623 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary Cemetery20 May 20

20 UNDERTAKER

ADDRESS

John M. Weber1803Bank St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43301

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43301

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3510 Walbrook Ave ST.; 15 WARD)

REGISTERED No. C _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth C. Hart(Residence in Baltimore: No. 3510 Walbrook Ave St.; 69 yrs., 10 mos., 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

white

5-STATUS:

Widow

6-DATE OF BIRTH,

July 15 - 1850

(Month)

(Day)

(Year)

7-AGE,

69 yrs., 10 mos., 3 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

B. M. Shaw

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Johnson

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alie Hart-Suter(Address) 3510 Walbrook Ave

15-

Robert P. Harrison,

MAY 19 1920

191.

Burial Permit CL

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May181920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 12 1920, to May 18 1920,that I saw her alive on May 17 1920,and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bacterial)(Duration) 6 yrs., 10 mos., 3 ds.

CONTRIBUTORY (Secondary)

Ischemia(Duration) 1 yrs., 10 mos., 1 ds.

(Signed)

J. Love

M. D.

May 18 1920 (Address) 836 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 69 yrs., 10 mos., 3 ds. In the State 69 yrs., 10 mos., 3 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Wooden Parkers May 20 1920

20-UNDERTAKER

ADDRESS

W. J. Pickens North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43302

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43302

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *South Baltimore General Hospital*

REGISTERED NO. C

CITY OF BALTIMORE: (No. ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mrs Margaret Ray*(Residence in Baltimore: No. *2403 W. Franklin St* St. *74* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *widowed*6-DATE OF BIRTH, *August 24*, 18*46* (Month) (Day) (Year)7-AGE, *74* yrs. mos. ds. IF LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer). *add*9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Henry Wagner*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Mary Katharina Fritz*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Chris Collins*(Address) *Reisterstown*

15-

MAY 19 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 18*, 19*20* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 1*, 19*20*, to *May 18*, 19*20*, that I saw her alive on *May 18*, 19*20*, and that death occurred, on the date stated above, at *7.45* p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration)yrs.mos.ds.

CONTRIBUTORY *Chronic Interstitial Nephritis* (Secondary)

(Duration)yrs.mos.ds.

(Signed) *Walter Bee Fort* M. D.*May 18*, 19*20* (Address) *1213 Sigt St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *18* yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Charles*DATE OF BURIAL, *May 20, 1920*20-UNDERTAKER, *W. J. McNeel*ADDRESS, *North Ave*

N. B.—Every item of information should be carefully supplied. Additions and corrections should be made immediately. PHYSICIAN'S SIGNATURE. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43303

CERTIFICATE OF DEATH.

D43303

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1603 N. Register*ST.: *8* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Alex Clarke(Residence in Baltimore: No. *1603 N. Register*St.: yrs., mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

May 18, 1920.
(Month) (Day) (Year)

7-AGE,

..... yrs. mos. ds.

If LESS than 1 day,
8 1/2 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Infant*9-BIRTHPLACE,
(State or Country),*Baltimore, Md.*

10-NAME OF FATHER,

*James J. Clarke Jr.*11-BIRTHPLACE OF FATHER
(State or Country),*Balto. Md.*

12-MAIDEN NAME OF MOTHER

*Roxie Elwell*13-BIRTHPLACE OF MOTHER
(State or Country),*Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Lenora Deal*(Address) *1812 Chase St.*

15-

MAY 20 1920

ROBERT H. KRAUTER

Burial Place: *DEATH*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 19, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 18, 1920, to May 19, 1920,*that I saw him alive on *May 18, 1920,*and that death occurred, on the date stated above, at *4 30* m.

The CAUSE OF DEATH* was as follows:

Prematurity
(about eight months)
(Duration) yrs. mos. *1* ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *John S. Fitch*

M. D.

5719 1920 (Address) *3522 Greenmount Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mount Carmel Cem.

DATE OF BURIAL,

May 22, 1920.

20-UNDERTAKER

John K. K. Co.

ADDRESS

8008 Delmar

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43304

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

P43304

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. German Aged Home

2-FULL NAME Nicolaus Schmidt

(a) RESIDENCE. No. German Aged Home
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos.

REGISTERED NO. 20
ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. WARD.

(If nonresident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 19, 1832

7 AGE

88

Months

1

Days

30

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Germany

10 NAME OF FATHER Heinrich C. Schmidt

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER Agnes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant German Aged Home Records
(Address) Baltimore & Payson Sts.

15

MAY 20 1920

ROBERT E. LAUTER
Registrar

Burial Permit 0108

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1920

17

I HEREBY CERTIFY, That I attended deceased from

March, 1920, to May 14, 1920.

that I last saw him alive on May 11, 1920.

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John H. Hoff, M. D.

, 19 (Address) 1543 W. Balt. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Co

May 20 1920

20 UNDERTAKER

Joseph B. Cook

ADDRESS
1403 N. Balt. St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43305

CERTIFICATE OF DEATH.

x38 D43305

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Providence Hospital* ST.; *11* WARD)

2-FULL NAME

(Residence in Baltimore: No. *887 8018 J. St.* St.; *4* yrs., *4* mos., *4* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*Cot*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Dec 31, 1889

(Month)

(Day)

(Year)

7-AGE,

30 yrs., 4 mos., 19 ds.

IF LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Housework*(b) General nature of industry, business, or establishment in which employed (or employer) *037*

9-BIRTHPLACE,

(State or Country), *Brunswick Ga*

PARENTS.

10-NAME OF FATHER, *Jesse Franklin*11-BIRTHPLACE OF FATHER (State or Country), *Ga*12-MAIDEN NAME OF MOTHER *Mattie Conway*13-BIRTHPLACE OF MOTHER (State or Country), *Ga*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jessie H. Stephenson*(Address) *818 J. Sparrow's Rd*

15-MAY 20 1920

ROBERT A. KRAUTER

Filed

101

Burial *Edgerton*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 19, 1920

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from *May 16, 1920*, to *May 19, 1920*, that I saw her alive on *May 19, 1920*, and that death occurred, on the date stated above, at *11:15* m.

The CAUSE OF DEATH* as follows:

Hysteria, Salpingitis, Oophoritis, Endometritis, Dissection of uterus & Ovaries, Shock

CONTRIBUTORY (Secondary)

(Signed) *J. B. Hughes* M. D.*May 19, 1920* (Address) *1413 D. Hall*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of death *4* yrs., *4* mos., *4* ds. In the State *4* yrs., *4* mos., *4* ds.Where was disease contracted, if not at place of death? *Sparrow's Point*Former or usual residence *"*19-PLACE OF BURIAL OR REMOVAL, *Edgerton Ga*DATE OF BURIAL, *May 22, 1920*20-UNDERTAKER *Sam'l H. Chase, Jr.*ADDRESS *1400 Mather*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43306

CERTIFICATE OF DEATH.

28

D43306

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 432.7. Ylmor ST.; 19 WARD)

2-FULL NAME

(Residence in Baltimore: No. 432.7. Ylmor St.; 20 yrs., 7 mos., 14 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Fem

4-COLOR OR RACE

W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH

Oct 13, 1899
(Month) (Day) (Year)

7-AGE

20 yrs., 7 mos., 14 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Homework

9-BIRTHPLACE, (State or Country),

Baltimore Md

10-NAME OF FATHER,

George W. Edwards

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER,

Pete Gray

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) 1. Pete Gray Edwards

(Address) 432.7. Ylmor

MAY 20 1920

ROBERT E. KRAUTER

Filed 191

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 17, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/20 1920, to 4/28 1920, that I saw h w alive on 4/28 1920, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs., 6 mos., 14 ds.

CONTRIBUTORY (Secondary)

Myocarditis (Duration) 3 yrs., 3 mos., 14 ds.

(Signed)

J. M. Hayden M. D.

7/17, 1920 (Address) 513 N. Wilmore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Carmel

May 23, 1920

20-UNDERTAKER

ADDRESS

Sam H. Case

1400 N. Mohr

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

D43307

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 D43302

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2313 Maryland Ave ST.; 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2313 Maryland Ave St.; 2 yrs., 6 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

October 24th, 1917
(Month) (Day) (Year)

7-AGE,

2 yrs., 6 mos., 28 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

None
none9-BIRTHPLACE,
(State or Country),Baltimore10-NAME OF
FATHER,Thomas Donald Elliott11-BIRTHPLACE
OF FATHER
(State or Country),Maryland12-MAIDEN NAME
OF MOTHEREthel R. Harper13-BIRTHPLACE
OF MOTHER
(State or Country),Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. T. Donald Elliott(Address) 2313 Maryland Ave

15-

MAY 20 1920

ROBERT E. KRAUTH

191... Clerk...
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5, 19, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
April 22 1920, to May 19 1920,
that I saw him alive on May 19 1920,
and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Acute endocarditis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY

(Secondary) as a result ofin Feb. 1920 (Duration).....yrs.....mos.....ds.(Signed) E. C. Polo

M. D.

May 19, 1920. (Address) 2034 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ✓ yrs. ✓ mos. ✓ ds. In the ✓ State ✓ yrs. ✓ mos. ✓ ds.Where was disease contracted, if not at place of death? ✓Former or usual residence ✓

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

New Cathedral CemeteryMay 20, 1920

20-UNDERTAKER

ADDRESS

L. V. Fussellbaugh2620 St Paul St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43308

CERTIFICATE OF DEATH.

* 40 D43308

1-PLACE OF DEATH *Church Home and Infirmary*

REGISTERED NO. C

CITY OF BALTIMORE: (No. *N. Broadway* ST.; *6* WARD)

2-FULL NAME

Simon Vetepeky

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *Harve de Grace Md* St.; *11* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH

Unborn

(Month)

(Day)

(Year)

7-AGE,

*37**6**—*

yrs. mos. ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Tailoring

9-BIRTHPLACE,

(State or Country),

Russia

10-NAME OF FATHER,

Lair Vetepeky

11-BIRTHPLACE OF FATHER

(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Leah Rosinsky

13-BIRTHPLACE OF MOTHER

(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. Lewis

(Address)

1411 E. Baltimore

15-

MAY 20 1920

ROBERT B. RAUTER

Burial Permit Register

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 18, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*April 22, 1920, to May 18, 1920,*that I saw him alive on *May 18, 1920,*and that death occurred, on the date stated above, at *10:30 P.M.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach(Duration)....yrs....mos. *27* ds.CONTRIBUTORY.....
(Secondary)

(Duration)....yrs....mos....ds.

(Signed) *Walter T. Anderson, M. D.**May 18, 1920* (Address) *Church Home and Inf.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos. *27* ds. In the State....yrs....mos....ds.Where was disease contracted, if not at place of death? *Harve de Grace, Md.*Former or usual residence *Harve de Grace, Md.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Helweg Southern Ave., May 20 1920

20-UNDERTAKER

ADDRESS

Jack Lewis, 1411 E. Baltimore

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43309

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D43309

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2121 Eastern Ave ST.: 1 WARD)

2-FULL NAME

Stanislaw Szybuska

(a) RESIDENCE. NO. 2121 Eastern Ave ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Anthony Szybuska

6 DATE OF BIRTH (month, day, and year)

Sept. 9-1889

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

30

8

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Homeworker 037

(b) General nature of industry, business, or establishment in which employed (or employer)

at Home

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

Michael Reeves

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Michalina Szybuska

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Germany

14

Informant
(Address)

Michalina Reeves
2121 Eastern Ave

15

Filed

MAY 20 1920 ROBERT E. LAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18th 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 2, 1920, to May 18, 1920,

that I last saw her alive on May 18, 1920,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. 3 mos. 3 ds.

CONTRIBUTORY
(Secondary)

Asdema Lungs

(duration) 2 yrs. 2 mos. 2 ds.

18 Where was disease contracted?

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. L. Thompson, M. D.

(Address) 2013 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St Stanislaus

DATE OF BURIAL

5/21 1920

20 UNDERTAKER

William Gierkowski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43310

CERTIFICATE OF DEATH.

150 D43310
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST. *7* WARD)

2-FULL NAME

(Residence in Baltimore: No. *Hebrew Hospital* St.; yrs. mos. *19* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

M.

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

*May 6**1920*

(Month)

(Day)

(Year)

7-AGE,

13

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer).

Child 100

9-BIRTHPLACE, (State or Country),

Balto., Md.

10-NAME OF FATHER,

Levy -

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Sam Cohen

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed

*MAY 20 1920**ROBERT K. LAUTER**Barial Form*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*May 19**1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 6 19*20*, to *May 19* 19*20*,that I saw him alive on *May 19* 19*20*,and that death occurred, on the date stated above, at *8:30* m.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY..... (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....*Harry Friedman M.D.**5/20* 19*20* (Address).....*Hebrew Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. *13* ds. In the State yrs. mos. *13* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *107 S. Broadway*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Hebrew Hospital *5-20-20* 19*20*

20-UNDERTAKER ADDRESS

Jack Lewis, 1411 E. Balt.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43311

CERTIFICATE OF DEATH.

151 D43311

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 N. E. Glover ST.; 6 WARD)

2-FULL NAME

(Residence in Baltimore: No. 112 N. E. Glover St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

F

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) single

6-DATE OF BIRTH,

April 11, 1920
(Month) (Day) (Year)

7-AGE,

yrs. 1 mos. 9 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

model
godd

9-BIRTHPLACE, (State or Country),

Ba. U.

10-NAME OF FATHER,

George Hock

11-BIRTHPLACE OF FATHER (State or Country),

Ba. U.

12-MAIDEN NAME OF MOTHER

Gertrude Hopp

13-BIRTHPLACE OF MOTHER (State or Country),

Ba. U.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

George Hock

(Address)

112 N. E. Glover

MAY 20 1920 ROBERT E. KAUTER

Filed..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 10, 1920, to May 19, 1920,

that I saw him alive on May 12, 1920,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Gastritis

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pneumonia
(Duration)..... yrs. mos. ds.(Signed) R. E. Kauter M. D.9/19, 1920 (Address) 112 N. E. Glover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Sacred Heart Cem.

DATE OF BURIAL,

May 20, 1920

20-UNDERTAKER

Lilly and Jule

ADDRESS

403 S. W. 1st

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43312

CERTIFICATE OF DEATH.

D43312

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1927 Druid Hill av* ST.; *4* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1927 Druid Hill av* St.; *1* yrs., *1* mos., *1* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*Colored*5-SINGLE, *widower*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

1862
(Month) (Day) (Year)

7-AGE,

58

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Carpenter*

9-BIRTHPLACE,

(State or Country), *Md.*

10-NAME OF FATHER,

Hick Crooms

11-BIRTHPLACE OF FATHER

(State or Country), *Md.*

12-MAIDEN NAME OF MOTHER

Emily Crooms

13-BIRTHPLACE OF MOTHER

(State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Benj. D. Crooms Jr.*(Address) *2001 1/2 Mc Culloch*

15-

Filed

MAY 20 1920

ROBERT A. KRAUTER

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 19, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

*Apr 15, 1920, to May 19, 1920,*that I saw him alive on *May 19, 1920,*and that death occurred, on the date stated above, at *11* m.

The CAUSE OF DEATH* was as follows:

*Ac. Pneumonia -
toxic nephritis*(Duration) *2* yrs. *2* mos. *1* ds.CONTRIBUTORY (Secondary) *Influenza*(Duration) *7* yrs. *1* mos. *1* ds.(Signed) *E. W. Short* M. D.*May 19, 1920* (Address) *1512 Druid Hill av*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *1* yrs. *1* mos. *1* ds. In the State *1* yrs. *1* mos. *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Cath. Star Cem

DATE OF BURIAL,

May 21, 1920

20-UNDERTAKER

Geo. H. Holland

ADDRESS

6312 Mount Hope

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43313

CERTIFICATE OF DEATH.

91 D43313

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 myrtle ave ST.; 14 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1416 myrtle ave St.; 8 yrs., 4 mos., 3 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED, Single
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Jan'y 15, 1912
(Month) (Day) (Year)

7-AGE,

8 yrs., 11 mos., 3 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none9-BIRTHPLACE,
(State or Country),New Jersey

10-NAME OF FATHER,

Charles H. Molock11-BIRTHPLACE OF FATHER
(State or Country),Maryland

12-MAIDEN NAME OF MOTHER

Sarah Moorman13-BIRTHPLACE OF MOTHER
(State or Country),New Jersey

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Molock(Address) 1416 myrtle ave

15

MAY 20 1920

Filed....., 191.

ROBERT E. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 18th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 18th 1920, to May 17th 1920.that I saw her alive on May 18th 1920,and that death occurred, on the date stated above, at 9:25 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY malnutrition & Heart Asthenia
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) A. B. Lusk M. D.May 19th, 1920 (Address) 1110 Madison ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Anthon Church

DATE OF BURIAL,

May 20th, 1920

20-UNDERTAKER

St. Holland

ADDRESS

St. Anthon Church

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43314

CERTIFICATE OF DEATH.

D43314

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 Columbia Ave. ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

633

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female white Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Henry E. Hechenberger

6 DATE OF BIRTH (month, day, and year)

Jan 14, 1873

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47 4 4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

John Deckman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Elizabeth Beyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Henry E. Hechenberger
633 Columbia Ave.

15

MAY 20 1920ROBERT A. TRAUTER
Registrar
Burial Permit 0122

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 19 20

17

I HEREBY CERTIFY, That I attended deceased from

May 18, 19 20, to May 18, 19 20,that I last saw him alive on May 18, 19 20,and that death occurred, on the date stated above, at 9 1 m.

The CAUSE OF DEATH* was as follows:

Coronary Atherosclerosis
(duration) yrs. mos. 2 1 2

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.(Address) 602 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery May 20 19 20

20 UNDERTAKER

ADDRESS

For Founders Son 2178 Penn

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43315

CERTIFICATE OF DEATH.

40 D43315

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1722 Caroline St. ST.: 9 WARD)

2-FULL NAME

George Washington Eby

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

1722 Caroline St. ST.: 9 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Eby6 DATE OF BIRTH (month, day, and year) Feb 13 18547 AGE Years 66 Months 3 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Medical 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Bethel Lane Dist Co9 BIRTHPLACE (city or town) (State or country) Penn10 NAME OF FATHER Jacob Eby11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn12 MAIDEN NAME OF MOTHER Ann Eby13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

PARENTS

14 Informant (Address) Mary J. Eby
1722 Caroline St.

15

Filed

MAY 20 1920ROBERT E. KRAUTH
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1920

17 I HEREBY CERTIFY, That I attended deceased from

March 1 1920, to May 19 1920,that I last saw him alive on May 18 1920,and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency Due to
Vomiting + Carcinoma of
Stomach(duration) yrs. 2 1/2 mos. ds.

CONTRIBUTORY (Secondary)

Carcinoma of Stomach(duration) yrs. 2 1/2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) O. P. Carman M. D.54, 1920 (Address) 1707 Maryland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

BaltimoreMay 22 1920

20 UNDERTAKER

ADDRESS

John Cook1707 Maryland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43316

D43316

CERTIFICATE OF DEATH.

82

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.: *3* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Helene Ketterer

(a) RESIDENCE. No.

619 S. Dallas

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *8* yrs. mos. ds. How long in U. S., if of foreign birth? *25* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Charles Ketterer

6 DATE OF BIRTH (month, day, and year)

Jan 1-1888

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

abt 57

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Donat Ketterer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

H H

12 MAIDEN NAME OF MOTHER

H H

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

H H

14

Informant (Address)

Charles Ketterer 619 S. Dallas St

Filed *MAY 20 1920*

ROBERT H. KRAMER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 19 1920

17

I HEREBY CERTIFY, That I attended deceased from *May 6*, 1920, to *May 19*, 1920, that I last saw him alive on *May 19*, 1920, and that death occurred, on the date stated above, at *10.45 a m.*

The CAUSE OF DEATH* was as follows:

Cerebral embolus

(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *J. S. Ridgely* M. D.

. 19 (Address) *Mercy Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Funerary

May 21 1920

20 UNDERTAKER

Wm. Clark

ADDRESS

H + B No.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43317

CERTIFICATE OF DEATH.

175-003

D43317

PLACE OF DEATH

CITY OF BALTIMORE (No.)

Med. Gen. Hospital

ST.

10

WARD)

FULL NAME

Harvey J. Ehrhart

(Residence in Baltimore: No.)

1046 N. Central Ave

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

married

6-DATE OF BIRTH,

May

24, 1872

(Month)

(Day)

(Year)

7-AGE,

47 yrs., 11 mos., 21 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Iron worker

(b) General nature of industry, business, or establishment in which employed (or employer)

Bethlehem Steel Plant

9-BIRTHPLACE, (State or Country),

Pennsylvania

10-NAME OF FATHER,

John Ehrhart

11-BIRTHPLACE OF FATHER (State or Country),

Pennsylvania

12-MAIDEN NAME OF MOTHER

Eliz. Schell

13-BIRTHPLACE OF MOTHER (State or Country),

Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Katherine Ehrhart

(Address) 1046 N. Central Ave

15- MAY 20 1920

Filed

101

ROBERT E. BRAUTER

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

17

1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by Railroad train (accident)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. D. Hennessy M. D.

(Coroner.)

May 20 1920 (Address) 2802 Edgewood Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

(Accident) Bethlehem Steel Co. Bethlehem, Pa.

Former or usual residence 1046 N. Central Ave

19-PLACE OF BURIAL OR REMOVAL,

Shed Park Cemetery

DATE OF BURIAL,

May 20, 1920

20-UNDERTAKER

Henry Horck Sny

ADDRESS

1301 E. Bay St

D43318

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D43318

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 10

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Frederick R. Ackerman

(a) RESIDENCE. NO.

904 N. Central Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

50 yrs. 6 mos. 4

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

November 16, 1869

7 AGE

Years

Months

Days

If LESS than

1 day. hrs.

or min.

50

6

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shoe Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Bernard J. Ackerman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Frances Kellner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Miss Anna E. Ackerman
904 N. Central Ave

15

File

MAY 20 1920

ROBERT E. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 20, 1920

17

I HEREBY CERTIFY, That I attended deceased from

January 18, 1918, to May 20, 1920

that I last saw him alive on May 19, 1920

and that death occurred, on the date stated above, at 1:50 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration)

2 yrs. 4

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

7

mos.

ds.

18 Where was disease contracted if not at place of death?

at place of death

Did an operation precede death?

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Urinary Analysis

(Signed)

J. E. Lilly

M. D.

(Address)

501 S. West Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cemetery

May 21st 1920

20 UNDERTAKER

Henry Wood Sur

ADDRESS

120, E. Eppa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very
important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43319

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 S. Bond St.; 2 WARD)

2-FULL NAME

(Residence in Baltimore: No. 731 S. Bond St.; 1 yrs., 6 mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Jan 5, 1919 (Month) (Day) (Year)

7-AGE,

18

If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... (b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

PARENTS.

10-NAME OF FATHER,

Joseph Glomb.

11-BIRTHPLACE OF FATHER (State or Country),

Austria Poland.

12-MAIDEN NAME OF MOTHER

Antonia Grubel.

13-BIRTHPLACE OF MOTHER (State or Country),

Austria Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Glomb.

(Address) #731 S. Bond St.

15-

Filed MAY 20 1920 ROBERT R. KAUTER

Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 20, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15 1920, to May 20 1920, that I saw him alive on May 19 1920, and that death occurred, on the date stated above, at 3 AM. The CAUSE OF DEATH* was as follows:

Depth of Pericardium

(Duration) ... yrs. ... mos. ... ds. CONTRIBUTORY (Secondary) Cardiac Aschem

(Signed) W. H. Johnson D. 5/20 1920 (Address) 817 Kenmore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus.

DATE OF BURIAL,

May 21, 1920.

20-UNDERTAKER

M. J. Sadowski.

ADDRESS

705 S. Ann St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43320

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D43320

PLACE OF DEATH

CITY OF BALTIMORE (No. *111 W. 20 St* ST. *14* WARD)

FULL NAME *Anna Perry*

(Residence in Baltimore: No. *111 W. 20 St*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. *70* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Widow*

6-DATE OF BIRTH,

Feb *mon* *1880*
(Month) (Day) (Year)

7-AGE,

40 yrs. *0* mos. *0* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Cook *02+*

9-BIRTHPLACE,

(State or Country),

Colton Co Mo

10-NAME OF FATHER,

Lebmon

11-BIRTHPLACE OF FATHER

(State or Country),

Lebmon

12-MAIDEN NAME OF MOTHER

Lebmon

13-BIRTHPLACE OF MOTHER

(State or Country),

Lebmon

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Margaret Hodder*

(Address) *136 Richmond St*

15-

MAY 20 1920

ROBERT E. KAUTER

Filed *101*

Burial Permitted

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 16, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest*

thereon and from the evidence obtained by said *Inquest*

and that said deceased came to *death*

on the day *dated* above.

The CAUSE OF DEATH* was as follows:

Septicemic disease

of heart.

(Duration) *0* yrs. *0* mos. *0* ds.

CONTRIBUTORY

(Secondary)

(Duration) *0* yrs. *0* mos. *0* ds.

(Signed) *John H. Norman* M. D.

May 24 1920 (Address) *1292 Roland*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place *0* yrs. *0* mos. *0* ds. In the *0* yrs. *0* mos. *0* ds. State *0* yrs. *0* mos. *0* ds.

Where was disease contracted, if not at place of death? *0*

Former or usual residence *0*

19-PLACE OF BURIAL OR REMOVAL,

McLure

DATE OF BURIAL,

May 20, 1920

20-UNDERTAKER

Anna Hodder

ADDRESS

CERTIFICATE OF DEATH.

REGISTERED NO.

ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 1800 Linden Ave.

ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 50 yrs. 0 mos. 0 ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19th. 192

17 I HEREBY CERTIFY, That I attended deceased from
Oct 22nd, 1918, to May 14th, 1920,
that I last saw him alive on May 18th, 1920,
and that death occurred, on the date stated above, at 4³⁰ A. M.
The CAUSE OF DEATH* was as follows:

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	83	1	24	

(a) Trade, profession or particular kind of work Retired, 04

(b) General nature of industry, business, or establishment in which employed (or employer) merchant (laces)

(c) Name of employer

10 NAME OF FATHER Isaac Gump.

11 BIRTHPLACE OF FATHER (city or town).....
(State or country) **Germany,**

12 MAIDEN NAME OF MOTHER Samale Bechhofer.

13 BIRTHPLACE OF MOTHER (city or town).....Germany,
(State or country)

14 Informant Mrs Simpson,
(Address) Marlboro. *Ch*

18
FBI
MAY 20 1920
ROBERT E. KRAUTH

Arteriosclerosis; myocarditis

Symptoms
(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY Neocochis/Hummed deer
(Secondary)
-Rhosa (duration) — yrs. — mos. 12 ds.

18 Where was disease contracted _____
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?.....No.....

What test confirmed diagnosis?

(Signed) James P. Henderson, M. D.

May 20, 1920 (Address) 1707 Eulalie Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 21st 1920

20 UNDERTAKER	ADDRESS
<i>Wm. J. Sullivan</i>	<i>118 W. 4th St. S.</i>

Racial Equality Club

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43322

CERTIFICATE OF DEATH.

50 D43322

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: No.

ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15 MAY 20 1920

Filed..... 101..... ROBERT E. ELLIOTT,

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

I HEREBY CERTIFY, That I attended deceased from

March 4 1920, to May 18 1920,

that I saw him alive on May 16 1920,

and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Diabetes
(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Raymond J. Williams, M. D.
May 19, 1920 (Address) 106 W. Conway St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43323

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2002 Christian

ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Barbara M. Spangenberg

(Residence in Baltimore: No. 2002 Christian

St.; 34 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-STATUS,

WIDOWED, (Write the word.)

6-DATE OF BIRTH,

Aug 28, 1849

7-AGE,

70 yrs., 8 mos., 21 ds.

IF LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Edward Spangenberg

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Spangenberg

(Address) 2002 Christian St.

15-

MAY 20 1920

ROBERT B. KRAUTER

Barial Permit Officer

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 19, 1920

I HEREBY CERTIFY, That I attended deceased from Jan 1920, to May 18 1920, that I saw her alive on May 18 1920, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

nephritis

about

(Duration) 1 yrs., mos., ds.

CONTRIBUTORY (Secondary)

Cardiac Dilatation

(Duration) 6 yrs., mos., ds.

(Signed) Walter E. Krichman M.D.

May 19, 1920 (Address) 2002 N. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Catholic Mr. & Mrs. N. L. Fink

MAY 22 1920

20-UNDERTAKER

ADDRESS

2637 Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43324

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

D43324

PLACE OF DEATH

CITY OF BALTIMORE (No. 946 W Saratoga St. 18

2-FULL NAME Richard L. Dunn

(Residence in Baltimore: No. 946 W Saratoga St.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, (Month) (Day) (Year)

7-AGE, 64 yrs., mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Saloon (b) General nature of industry, business, or establishment in which employed (or employer), 040

9-BIRTHPLACE, (State or Country), Md.

10-NAME OF FATHER, Richard Dunn

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary J. Dunn

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. L. Dunn (Address) Kent Island Md.

15- MAY 20 1920 ROBERT A. FAUTHNER 101 Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy, or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't know

(Duration) yrs. mos. ds.

(Signed) W. B. Smith M. D. (Coroner)

51.20.1920 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 3/20/20

20-UNDERTAKER, J. A. Parnell ADDRESS, 1014 Union

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

140344043325 HEALTH DEPARTMENT—CITY OF BALTIMORE D43325

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *12th* WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Alfred Cook

(a) RESIDENCE. No. *914 Mc Donough* ST., WARD. (Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Caucasian* 5 Single, Married, Widowed, or Divorced (write the word) *Child*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Child*

6 DATE OF BIRTH (month, day, and year) *March 27-1919*

7 AGE *1* Years *1* Months *21* Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.* (State or country)

10 NAME OF FATHER *Dan Bates*

11 BIRTHPLACE OF FATHER (city or town) *D. C.* (State or country)

12 MAIDEN NAME OF MOTHER *Elta Cook*

13 BIRTHPLACE OF MOTHER (city or town) *Md.* (State or country)

14 Informant *Hospital Record* (Address) *26 St.*

15 *MAY 20 1920*

ROBERT J. CRUTTER Registrar
Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 18 1920*

17 I HEREBY CERTIFY, That I attended deceased from *April 20, 1920* to *May 18, 1920*, that I last saw *him* alive on *May 18, 1920*, and that death occurred, on the date stated above, at *3:50* p. m.

The CAUSE OF DEATH* was as follows: *Disseminated Tuberculosis (abscesses, bone, general military, lungs)* (duration) yrs. *3* mos. ds.

CONTRIBUTORY *None* (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*

Did an operation precede death? *Yes* Date of *4/20/20*

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Autopsy* (Signed) *Harold L. Higgins, M. D.*

5/20, 1920 Address *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Asbury *May 20 1920*

20 UNDERTAKER *John W Henderson* ADDRESS *1502 E 4th Street*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43326

D43326

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Shotts.(a) RESIDENCE. NO. UnknownST., Unknown WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
<u>Female</u>	<u>White</u>	<u>Single</u>

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<u>55</u>				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)14 Informant Hospital Records(Address) New City Hospital15 MAY 20 1920 ROBERT A. CLAUSER
Registrar

Bertel Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 19 20

17 I HEREBY CERTIFY, That I attended deceased from
January 16, 19 20, to May 18, 19 20
that I last saw him alive on May 18, 19 20
and that death occurred, on the date stated above, at 9:00 A.m.
The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis(duration) 3 yrs. — mos. — ds.CONTRIBUTORY
(Secondary)(duration) 2 yrs. — mos. — ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No especial test(Signed) W. B. Bowman, M. D.May 18 19 20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND.May 20 1920

20 UNDERTAKER

ADDRESS

Commissioner Health.May 20 1920

169

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43327

X 28

REGISTERED NO...

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

4

ST., WARD.

(Usual place of abode) _____ (If nonresident give city or town and State) _____

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., If of foreign birth yrs. mos. d

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S. If of foreign birth yrs. mos. d

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 19 20

17 I HEREBY CERTIFY, That I attended deceased from
May 17, 1920, to May 19, 1920,
that I last saw her alive on May 19, 1920,
and that death occurred, on the date stated above, at 8:05 p.m.

The CAUSE OF DEATH* was as follows: *Acute &*
Myocardial Insufficiency

The CAUSE OF DEATH* was as follows: *Acute &*
Myocardial Insufficiency

(duration) yrs. mos. /

CONTRIBUTORY (Secondary) *Spontaneous Pneumo-*
thorax (duration) *unknown* yrs. mos.

18 Where was disease contracted
if not at place of death? Rock Springs
Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? _____

(Signed) Carl Kerschner M.

5/19/1971 (Address) University of North Carolina

*State the Disease Causing Death or in deaths from Violent Causes

state (1) Means and Nature of Injury, and (2) whether Accidents, Suicidal, or Homicidal. (See reverse side for additional space.)

[illegible]

Quarryville Pa. May 20 1901

20 UNDERTAKER	ADDRESS
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Funeral Permit Clerk

Registrar

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43328

CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *15 A Bond* St. *3* WARD)2-FULL NAME *Mignon Middel Gardner*(Residence in Baltimore: No. *15 A Bond* St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *Oct 3, 1918*
(Month) (Day) (Year)7-AGE, *1 yrs. 7 mos. 17 ds.* If LESS than 1 day, ...hrs. or ...min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Baltimore Md*10-NAME OF FATHER, *John L. Gardner*11-BIRTHPLACE OF FATHER (State or Country), *Somerset Co. Md*12-MAIDEN NAME OF MOTHER *Lucy V. Muir*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John L. Gardner*(Address) *15 A Bond St*

15-

Robert P. Harrison,

MAY 20 1920 191. Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 20, 1920*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 7, 1920*, to *May 20, 1920*, that I saw him alive on *May 19, 1920*, and that death occurred, on the date stated above, at *8:30 a.m.*

The CAUSE OF DEATH* was as follows:

Measles
(Duration) yrs. mos. ds. *10 ds.*CONTRIBUTORY (Secondary) *Pneumonia*(Duration) yrs. mos. ds. *3 ds.*(Signed) *E. B. Patton* M. D.*May 20, 1920* (Address) *1711 E. B. Patton St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Newton Somerset Co. Md *May 20, 1920*

20-UNDERTAKER ADDRESS

Harry E. Hughes *17 S. Bway**Baltimore*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43329

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43329

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Bridg 4. R.R. Hobbs*
CITY OF BALTIMORE (No. *Charles A. Mays* ST.: *175* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *734 E. Preston*
(Residence in Baltimore: No. *734 E. Preston* St.; yrs., *10* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *White* 5-STATUS *Married*
6-DATE OF BIRTH, *Oct 2, 1893*
(Month) (Day) (Year)
7-AGE, *26* yrs. *7* mos. *17* ds. If LESS than 1 day, ... hrs. or ... min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Signal 086*
(b) General nature of industry, business, or establishment in which employed (or employer). *Filter*

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Registration Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 19, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an. *Examination*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said. *Examination*
(Inquest, au-

... and that said deceased came to death topsy or inquiry.) on the day stated above.

THE CAUSE OF DEATH* was as follows:

Examination by R.R. engine
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Robert P. Harrison* M. D.
(Coroner)

22, 19*20* (Address) *3539 Ball Rd*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

MAY 20 1920

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43330

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43330

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

1339 N. Calhoun

WARD)

15

REGISTERED No. C

2-FULL NAME

Carroll Criss

(Residence in Baltimore: No.

1339 N. Calhoun

St.; yrs. 3 mos. 13 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

black

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

single

6-DATE OF BIRTH,

Feb. 5, 1919

(Month)

(Day)

(Year)

7-AGE,

1 yrs. 3 mos. 13 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE,

(State or Country).

Balto. Md.

10-NAME OF FATHER,

John Slater

11-BIRTHPLACE OF FATHER,

(State or Country).

Virginia

12-MAIDEN NAME OF MOTHER

Mary Criss

13-BIRTHPLACE OF MOTHER,

(State or Country).

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Criss

(Address)

1339 N. Calhoun St.

15-

Robert F. Harrison,

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 18, 1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

(Inquest, autopsy or inquiry.)

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. D. Hennessy, M. D.

(Coroner.)

May 18, 1920, (Address) 2802 E. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

St. Auburn

DATE OF BURIAL,

May 20, 1920

20-UNDERTAKER

Edward Ringgold

ADDRESS

1463 N. Carey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43331

CERTIFICATE OF DEATH.

X 161

D43331

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 19, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an.....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal injuries prob. fr. d. struck -

9 min. (Duration).....
CONTRIBUTORY (Secondary).....
(Duration).....

(Signed)..... M. D.
(Coroner).....

May 20 1920. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place..... In the of death..... State.....

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER ADDRESS

MAY 20 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43332

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Julius Kephner Hospital* ST.: *5th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Helen Novak

(a) RESIDENCE. NO.

1022 E. Fayette St. Baltimore Md.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

X

6 DATE OF BIRTH (month, day, and year)

Jan., 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1**11**11*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Peter Novak

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Martha Schender

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant (Address)

*7444 Records**Robert P. Harrison*

MAY 20 1920

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-19 1920

17

I HEREBY CERTIFY, That I attended deceased from

*May 12 1920, to May 19 1920.*that I last saw her alive on *May 19 1920.*and that death occurred, on the date stated above, at *8:20 P. m.*

The CAUSE OF DEATH* was as follows:

Pneumonia primary lobar, acute

(duration)

yrs.

mos.

26 ds.

CONTRIBUTORY (Secondary)

None

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

*home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *X-Ray*

(Signed)

*Harold L. Stegman, M. D.*570 19th (Address)*Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Trinity Cemetery**May 22 1920*

20 UNDERTAKER

ADDRESS

418 E 21st

D43333

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43333

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1008 McCulloh* ST.: *11* WARD)

2-FULL NAME

Mildred Lowe

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

1008 McCulloh

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *6* yrs. *2* mos. *22* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Child*6 DATE OF BIRTH (month, day, and year) *Feb 26, 1914*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
6 *2* *22*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Maryland*
(State or country)10 NAME OF FATHER *Charles T. Lowe*11 BIRTHPLACE OF FATHER (city or town) *Howard Co. Md.*
(State or country)12 MAIDEN NAME OF MOTHER *Annie Garrison*13 BIRTHPLACE OF MOTHER (city or town) *Howard Co. Md.*
(State or country)14 Informant *Charles T. Lowe*
(Address) *1008 McCulloh St.*

MAY 20 1920 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 19 1920*17 I HEREBY CERTIFY, That I attended deceased from *May 15, 1920* to *May 19, 1920*, that I last saw her alive on *May 19, 1920*, and that death occurred, on the date stated above, at *6:20 P. m.*

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs(duration) yrs. *5* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *No*(Signed) *W. William Fry* M. D.5/20, 1920 (Address) *1928 Penna. Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Western Star**May 21 1920*

UNDERTAKER

*Edward W. Pyle*ADDRESS *903**Edmundson*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Pks.

D43334

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D43334

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 Bolton ST.; 11 WARD)

REGISTERED No. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Lincoln Bullett

(a) RESIDENCE. No. 1121 Bolton ST., _____ WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Feb. 29-1920

7 AGE Years _____ Months 2- Days 21 If LESS than 1 day, _____ hrs. _____ or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Balt. (State or country) md

10 NAME OF FATHER Chas. Bullett

11 BIRTHPLACE OF FATHER (city or town) Lafayette (State or country) Ky.

12 MAIDEN NAME OF MOTHER Fattie Duckert

13 BIRTHPLACE OF MOTHER (city or town) Lafayette (State or country) Ky.

14 Informant Chas. Bullett (Address) 1121 Bolton St.

15 Filed May 20 1920 19 _____ Registrar Robert P. Harrison

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-19th 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to May 17, 1920,

that I last saw him alive on May 17, 1920,

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) _____ yrs. _____ mos. 14 ds.

CONTRIBUTORY Mal. nutrition & Bad nour- (Secondary) ishment

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted _____ If not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edward J. Wheatley, M. D.

(Address) 1230 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Laurel Cove
Samuel J. Jansley

May 21 1920
578 N. E. Ave.

D43335

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43335

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *530 Orchard* ST. *17* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *530 Orchard* St. *17* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *Caucasian* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Infant*6-DATE OF BIRTH, *Oct 19, 1918*
(Month) (Day) (Year)7-AGE, *1* yrs. *7* mos. ds. IF LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Infant*
(b) General nature of industry, business, or establishment in which employed (or employer) *000*9-BIRTHPLACE, (State or Country), *Balto Md*10-NAME OF FATHER, *Jas. A. Wilson*11-BIRTHPLACE OF FATHER (State or Country), *Balto Md*12-MAIDEN NAME OF MOTHER, *Lillian Jackson*13-BIRTHPLACE OF MOTHER (State or Country), *Balto Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Lillian Jackson*(Address) *530 Orchard St*

15- Robert P. Harrison,

MAY 20 1920 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 19, 1919*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 16* 191, to *May 19* 191, that I saw him alive on *May 19* 191, and that death occurred, on the date stated above, at *7 a* m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatitis
(Duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) *J. H. Hadden* M. D. *5/19/19* (Address) *117 N. Calver*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20-UNDERTAKER ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43336

CERTIFICATE OF DEATH.

92

D43336

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2916 Mosher St ST. 16 WARD)

2-FULL NAME

Catherine W. Grill

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2916 Mosher St St. 2 yrs. 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

F

4-COLOR OR RACE

X5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH

May 15, 1864
(Month) (Day) (Year)

7-AGE

56 yrs. 4 mos. 1 ds.

If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country)

Baltimore

10-NAME OF FATHER

August Otto

11-BIRTHPLACE OF FATHER (State or Country)

Germany

12-MAIDEN NAME OF MOTHER

Margaret Hise

13-BIRTHPLACE OF MOTHER (State or Country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

P. August Grill

(Address)

613 Base date st

15 MAY 21 1920

Filed, 191..

ROBERT A. KAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 19, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 10, 1920, to May 19, 1920, that I saw her alive on May 19, 1920, and that death occurred, on the date stated above, at 1:55 p.m.
The CAUSE OF DEATH* was as follows:Lobar pneumonia
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Signed) Joseph N. Zierler M. D.
May 20, 1920 (Address) 1003 Poplar Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

May 21, 1920

20-UNDERTAKER

George J. Smith

ADDRESS

1003 H. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43337

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

MEDICAL CERTIFICATE OF DEATH.

20 1920

The CAUSE OF DEATH* was as follows:

Filed....., 191... **Registrar.**

ADDRESS 147

20-UNDERTAKER *John H. Toadon* ADDRESS *142 North St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43338

D43338

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 244-Pearl

ST.: 4

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Little Carroll*(a) RESIDENCE. NO. *244 Pearl St*

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *36* yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Blk* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*George Carroll*6 DATE OF BIRTH (month, day, and year) *mch 1853*7 AGE Years Months Days *67 — 2 —* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *St Marys Co Md* (State or country)10 NAME OF FATHER *Richard Holmes*11 BIRTHPLACE OF FATHER (city or town) *St Marys Co Md* (State or country)12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) *St Marys Co Md* (State or country)14 Informant *Robert Carroll* (Address) *1009 David Hill st*

15 MAY 21 1920 ROBERT E. BLANTER

Boris J. Smith Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 19th* 19 *20*17 I HEREBY CERTIFY, That I attended deceased from *May 15th* 19 *20*, to *May 19*, 19 *20*.that I last saw her alive on *May 18th*, 19 *20*, and that death occurred, on the date stated above, at *845a* m.

The CAUSE OF DEATH* was as follows:

Apoplexy —(duration) yrs. mos. *4* ds.CONTRIBUTORY *coma* (Secondary)(duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Eustas Goldman*, M. D., 19 (Address) *1016 W Franklin*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Int Auburn Cem**May 21st 1920*

20 UNDERTAKER

W. H. Holland

ADDRESS

1631 Union Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43339

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 N. Wolfe ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 706 N. Wolfe St.; 2 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)6-DATE OF BIRTH, November 22nd, 1869 (Month) (Day) (Year)7-AGE, 50 yrs., 6 mos., 26 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. 037
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), Germany10-NAME OF FATHER, Wilhelm Hauser11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER, Brant13-BIRTHPLACE OF MOTHER (State or Country), Long Run

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

+ (Informant) R. Strecker
(Address) 706 N. Wolfe

15-MAY 21 1920

Filed, 191..

ROBERT A. KRAUTER

Notary Public for Baltimore

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 19th, 1920 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from eternity 13, 1920, to May 19th, 1920, that I saw h^e alive on May 18th, 1920, and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Regeneration and Chronic Nephritis
(Duration) 5 yrs., 0 mos., 0 ds.

CONTRIBUTORY (Secondary)

(Signed) J. Albert Singmaster, M. D.
5/19/1920 (Address) 613 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, TrinityDATE OF BURIAL, May 21, 192020-UNDERTAKER, Gorkler & GorklerADDRESS 1739Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43340

CERTIFICATE OF DEATH.

79 D43340
REGISTERED No. C1-PLACE OF DEATH *Hebrew Hospital*
CITY OF BALTIMORE: (No. *Monument Street* ST.; *5* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Lena Friedenberg*
(Residence in Baltimore: No. *213 N. Front* St.; *40* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *female* 4-COLOR OR RACE. *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *married*
(Write the word.)6-DATE OF BIRTH. *Unknown*, *1887*
(Month) (Day) (Year)7-AGE. *69* yrs. *—* mos. *—* ds. If LESS than 1 day, *—* hrs. or *—* min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer). *037*9-BIRTHPLACE, (State or Country), *Russia*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Russia*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Lewis*(Address) *1411 E. Baltimore*15- *MAY 21 1920* *ROBERT A. LAUTER*
FILED *DEPT. HEALTH*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 21*, *1920*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *5-14-1920*, to *5-21-1920*, that I saw her alive on *5-20-1920*, and that death occurred, on the date stated above, at *1:05* p.m.The CAUSE OF DEATH* was as follows:
Myocardial insufficiency
(Duration) *1/2* yrs. *5* mos. *—* ds.CONTRIBUTORY (Secondary) *slight*
lung (Duration) *1/2* yrs. *7* mos. *—* ds.
(Signed) *Benj. Sacks* M. D.
May 21, 1920 (Address) *Hebrew Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs. *—* mos. *7* ds. in the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *213 N. Front St.*19-PLACE OF BURIAL OR REMOVAL, *Hebrew Hospital* DATE OF BURIAL, *5/21/1920*20-UNDERTAKER *Jack Lewis* ADDRESS *1411 E. Baltimore*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43341

CERTIFICATE OF DEATH.

D43341

1-PLACE OF DEATH *Hebrew Hospital*

REGISTERED NO. C

CITY OF BALTIMORE: (No. *Monument St*)ST.: *21* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Simon Beckhardt*(Residence in Baltimore: No. *1235 Nanticoke St* St.; *48* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

Aug 3rd, *1869*
(Month) (Day) (Year)

7-AGE,

50 yrs. *9* mos. *16* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Product-dealer *045*

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Abraham Beckhardt

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Julia Hestich

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Helen Beckhardt

(Address)

1131 Nanticoke St.

15-

MAY 21 1920

ROBERT B. KAUTER

Filed.....

191..

BUTLER PERMIT OFFICE
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May, *19*, *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Feb. 25, *1920*, to *May 19*, *1920*,that I saw him alive on *May 19*, *1920*,and that death occurred, on the date stated above, at *11⁴⁵* p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

.....

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY.....
(Secondary)*Nephritic abscesses*

..... (Duration)..... yrs..... mos..... ds.

(Signed)

Charles S. Levy, M. D.*St. 19-20 191...* (Address) *Hebrew Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Linden Park Cem

DATE OF BURIAL,

5/21/20, *1920*

20-UNDERTAKER

John Howard Son

ADDRESS

401 N. Hollis St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43342

CERTIFICATE OF DEATH.

D43342

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mount Hope Reform* ST. *28* WARD)

2-FULL NAME

Michael McCarthy

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

Mount Hope Reform

ST. *28* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *28* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *Don't know* mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 4 1849*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *70 0 0 0*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labour 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *M*

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Daniel McCarthy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Co. Mayo

12 MAIDEN NAME OF MOTHER

Mary Brogue

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Co. Mayo

Ireland

14

Informant (Address)

Records of Mt Hope Reform Mt Hope Baltimore

15

MAY 21 1920

ROBERT E. KRAUTER

Baptist Permit 01011

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 20 1920*

17 I HEREBY CERTIFY, That I attended deceased from *Feb 16 1892* to *May 20 1920*, that I last saw him alive on *May 19 1920*, and that death occurred, on the date stated above, at *9:45 A.* m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial)

(duration) *0* yrs. *0* mos. *3* ds.

CONTRIBUTORY (Secondary)

Ch. Malaria

(duration) *28* yrs. *0* mos. *0* ds.

18 Where was disease contracted?

if not at place of death? *Not at home Mary Land (?)*

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Frank J. Flannery* M. D.

May 20 1920 (Address) *Mt Hope Reform*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Cemetery

DATE OF BURIAL

May 21 1920

20 UNDERTAKER

STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43343

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3731 O'Donnell St. ST. 26 WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

7 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Elizabeth Bair

6 DATE OF BIRTH (month, day, and year)

April 11-1855

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

65

1

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

Pres. Elevator

(c) Name of employer

Co. -

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

John Bair

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Germany

14

Informant (Address)

Elizabeth Bair 3731 O'Donnell St.

MAY 21 1920

ROBERT B. LEAFTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to May 19, 1920.

that I last saw him alive on May 19, 1920.

and that death occurred, on the date stated above, at 4:15 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Spleen & Lungs

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) J. B. Tellow M. D.

20, 1920 (Address) 2421 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer Cem.

DATE OF BURIAL

May 22 1920

20 UNDERTAKER

Lilly & Zeller

ADDRESS

403 S. W. St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43344

CERTIFICATE OF DEATH.

D43344

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 N. Clinton St. ST. 26 WARD)

2-FULL NAME

Catharine Schuck

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

3 N. Clinton St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 23-1910

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.9526

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore
md.

10 NAME OF FATHER

Conrad Schuck

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto.
md.

12 MAIDEN NAME OF MOTHER

Mollie Margertha

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto.
md.

14

Informant
(Address)Conrad Schuck
3 N. Clinton St.

MAY 21 1920

ROBERT E. ELLAUTER
Registrar

Burial Permit Closed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 14 1920

17

I HEREBY CERTIFY, That I attended deceased from

Jan 15, 1920, to May 18, 1920,
that I last saw her alive on May 18, 1920,
and that death occurred, on the date stated above, at 12:50 p.m.

The CAUSE OF DEATH* was as follows:

CardiacCONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1920 (Address)

M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cem.May 21 1920

20 UNDERTAKER

Lilly & Ziehl

ADDRESS

403 S. Wolfe St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43345

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (Municipal Tuberculosis Hospital) 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Felton

(a) RESIDENCE. No. 17 Smith Court (Hampstead Court) ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina (State or country)

10 NAME OF FATHER John H. Felton

11 BIRTHPLACE OF FATHER (city or town) North Carolina (State or country)

12 MAIDEN NAME OF MOTHER Eliza Perry

13 BIRTHPLACE OF MOTHER (city or town) North Carolina (State or country)

14 Informant Hospital Records (Address) M.T.H.

15 MAY 21 1920 ROBERT F. KAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19th 1920

17 I HEREBY CERTIFY, That I attended deceased from March 2nd, 1920, to May 19th, 1920,

that I last saw her alive on May 18th, 1920,

and that death occurred, on the date stated above, at 7.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY Chronic nephritis (Secondary)

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis T.B. in sputum

(Signed) George R. Wilkinson, M. D.

May 19 1920 (Address) Municipal Tuberculosis Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Daniel Green

May 22 1920

20 UNDERTAKER

William Cook

ADDRESS

507 2 North Ave

HUM 74

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43346

CERTIFICATE OF DEATH.

28
REGISTERED NO. C

D43346

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 N. Pulaski ST.; 20 WARD)

2-FULL NAME

(Residence in Baltimore: No. 408 N. Pulaski St.; Life yrs. 6 mos. 19 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, Married
(Write the word.)6-DATE OF BIRTH, November 1, 1864
(Month) (Day) (Year)7-AGE 33 yrs. 6 mos. 19 ds. If LESS than 1 day,hrs. ormin.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Receiving Clerk
(b) General nature of industry, business, or establishment in which employed (or employer). Hutzel Bros9-BIRTHPLACE, (State or Country), Balto Md.10-NAME OF FATHER, Zachariah S. Million11-BIRTHPLACE OF FATHER (State or Country), Don't Know12-MAIDEN NAME OF MOTHER Lucinda Gosnell13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary C. Million(Address) 408 N. Pulaski St.15- MAY 21 1920 ROBERT E. KAUTER16- Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 19, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from 1918, to May 19, 1920, that I saw him alive on May 19, 1920, and that death occurred, on the date stated above, at 2:15 P.m.The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis2 to 3 yrs. 6 mos. 19 ds.CONTRIBUTORY (Secondary) X(Signed) J. H. Hoffmann M. D.
5/20/1920, 1920 (Address) 112100 N. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. 6 mos. 19 ds. In the State 1 yrs. 6 mos. 19 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn DATE OF BURIAL, May 22, 192020-UNDERTAKER William Cook ADDRESS 503 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43347

D43347

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *2808 Walbrook* ST. *15* WARD)2-FULL NAME *Rachel A. Sparrow*(a) RESIDENCE. NO. *2808 Walbrook* ST. *15* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed,
or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of *John H. Sparrow*6 DATE OF BIRTH (month, day, and year) *Nov 25-1851*

7 AGE

Years *68*Months *5*Days *24*If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work *At Home*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) *Balto Md*10 NAME OF FATHER *Henry Groom*11 BIRTHPLACE OF FATHER (city or town)
(State or country) *Mass*12 MAIDEN NAME OF MOTHER *Catherine Hilbrand*13 BIRTHPLACE OF MOTHER (city or town)
(State or country) *Balto Md*

14

Informant *John H. Sparrow*
(Address) *2808 Walbrook St NW*

15

Filed *MAY 21 1920* *ROBERT H. BRADLEY*

19

Burial Permit *0168*

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 19th* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from
March 15th 19 *20*, to *May 19th* 19 *20*.that I last saw her alive on *May 19th* 19 *20*.and that death occurred, on the date stated above, at *1:30 am* m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease(duration) *7* yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? *Balto*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *J. E. Jones*, M. D.19. 1920 (Address) *720 W. North Ave.**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Ludow Park**May 21 1920*

20 UNDERTAKER

ADDRESS

*William Cook**502 E. North Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43348

CERTIFICATE OF DEATH.

120

D43348

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1914 N. Pat. Park St. 8

WARD)

2-FULL NAME

Margaret E. Kitting

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

(Usual place of abode)

914 N. Pat. Park St. 8 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Columbus Götting

6 DATE OF BIRTH (month, day, and year)

Mar 17 1863

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

57

2

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Annapolis Md.

10 NAME OF FATHER

Charles Götting

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Martha Götting

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant
(Address)Columbus Götting
914 N. Pat. Park St.

15

MAY 21 1920

ROBERT R. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 20 1920

17

I HEREBY CERTIFY, That I attended deceased from

Dec 29, 1919, to May 20, 1920,

that I last saw him alive on May 19, 1920,

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Hyatt M. D.

19 (Address) 35 E. Montgomery St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Home

May 27 1920

20 UNDERTAKER

J. M. Cook

ADDRESS

J. M. Cook

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

043349

CERTIFICATE OF DEATH.

28 043349

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 Jackson

ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John E. Burgers

(a) RESIDENCE. NO.

1707 Jackson

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

Mary Welles

6 DATE OF BIRTH (month, day, and year)

Apr. 7, 1892

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

28

1

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman

066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt. Ind.

10 NAME OF FATHER

James V. Burgers

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt. Ind.

12 MAIDEN NAME OF MOTHER

Josephine Schutz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt. Ind.

14

Informant (Address)

Josephine V. Burgers 1707 Jackson

15

File

MAY 21 1920

ROBERT R. KAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 19 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 7 1920 to May 19 1920

that I last saw him alive on May 19 1920

and that death occurred, on the date stated above, at 7:25 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs.

Unknown.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. J. Seabury M. D.

5/19/19 (Address) 638 7th Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Olivet Cemetery May 21 1920

20 UNDERTAKER

ADDRESS

Mr. J. E. Evans 1448 Charles

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43350

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109 D43350

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Dg Hospital* ST. *21* WARD)2-FULL NAME *William Rolston*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. *1212 Glyndon Ave*, ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

*single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *June 24-1895-*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*24**10**25 da*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*City*9 BIRTHPLACE (city or town) *Balto*
(State or country) *md.*10 NAME OF FATHER *Thos. Rolston*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Ireland*12 MAIDEN NAME OF MOTHER *Anna Wilkens*13 BIRTHPLACE OF MOTHER (city or town) *Balto*

(State or country)

md.

14

Informant

(Address)

William Wilkens
1212 Glyndon Ave

15

*MAY 21 1920**ROBERT A. CRUTTER*

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 19 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*May 16, 1920, to May 19, 1920,*that I last saw him alive on *May 19, 1920,*and that death occurred, on the date stated above, at *2:20 P. m.*

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *yes* Date of *May 16-20*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Newton S. Parr*, M. D., 19 (Address) *Franklin Dg. Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Louisa Park

DATE OF BURIAL

May 20 1920

20 UNDERTAKER

Harry H. Hitzke

ADDRESS

1531 W. ...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43351-8

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43351

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1338 Columbia Ave.

ST. 21

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Emmeline E. Pitcher

(a) RESIDENCE. NO.

133 Columbia Ave.

ST.

WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

Life

yrs.

mos.

How long in U. S., if of foreign birth?

Life

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Fountain L. Pitcher

6 DATE OF BIRTH (month, day, and year)

Feb 28, 1869

7 AGE

Years

Months

Days

If LESS than

51

2

20

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Robert Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Emily Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant
(Address)Fountain L. Pitcher
1338 Columbia Ave

15

MAY 21 1920

ROBERT A. ELLIOTT
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 19 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 1, 1920, to May 19, 1920

that I last saw him alive on May 15, 1920

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Chronic Fibroid Uterus
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.

Address 612 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cedar Hill Cemetery

DATE OF BURIAL

May 21 1920

20 UNDERTAKER

Harry E. Nitzke

ADDRESS

1531 Lombard St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Hester Plater

(a) RESIDENCE

No 1137 W. Sanatoga

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

-

6 DATE OF BIRTH (month, day, and year)

Dec 29, 1889

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

30621

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Richard Plater

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Eggerson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

J. H. A. Records

15

MAY 21 1920ROBERT A. LEATHER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 13 1920, to May 19 1920,that I last saw her alive on May 19 1920and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Peritonitis following operation for pelvic abscess(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

Chronic Pelvic Inflammation(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 14, 20Was there an autopsy? NoWhat test confirmed diagnosis? None

(Signed)

Leo B. Burch

M. D.

, 19

(Address)

Johns Hopkins Hospital, Balt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Zion ChurchMay 23 1920

20 UNDERTAKER

John H. Toadwin

ADDRESS

143 W. Hill St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D43353

HEALTH DEPARTMENT-CITY OF BALTIMORE
CERTIFICATE OF DEATH.

REGISTERED NO. C

D43353

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *University Hospital* St. *17*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Joma Ready

(Residence in Baltimore: No. *734 Bradley St.*)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

July 22, 1912
(Month) (Day) (Year)

7-AGE,

7 yrs., 10 mos., 27 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

School girl

9-BIRTHPLACE, (State or Country),

Beth City

10-NAME OF FATHER,

Joseph Ready

11-BIRTHPLACE OF FATHER (State or Country),

Ind.

12-MAIDEN NAME OF MOTHER

Johna Traylor

13-BIRTHPLACE OF MOTHER (State or Country),

Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joma Ready*

(Address) *734 Bradley St.*

15-

MAY 21 1920

ROBERT N. LAUTER

FILE

191

BORIS F. B. REGISTAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

find that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH* was as follows:

severe lacerations on body caused by accidental falling from a clothesline

CONTRIBUTORY *Accidental*

(Duration) *12 mos., 12 ds.*

(Signed) *H. K. Gorman* M. D.

5.20, 1920 (Address) *117 N. Saratoga*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *12 mos., 12 ds.* In the State *12 mos., 12 ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Brooks Montgomery Co. Ind. May 23, 1920

20-UNDERTAKER

ADDRESS

John H. Traylor *143*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D43354

CERTIFICATE OF DEATH.

150 D43354

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1939 White)

2-FULL NAME

(Residence in Baltimore: No. 1939 White Dr.)

ST. 20

WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, black 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, May 19, 1920 (Month) (Day) (Year)

7-AGE, If LESS than 1 day, 10 hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, nurse (b) General nature of industry, business, or establishment in which employed (or employer), 800

9-BIRTHPLACE, (State or Country), Balto. Md.

10-NAME OF FATHER, Percy Coates

11-BIRTHPLACE OF FATHER, (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Barran

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. P. Coates (mother)

(Address) 1939 White Dr.

15- MAY 21 1920 ROBERT F. ERAUTER

REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 19, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(Duration) yrs. mos. / ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. / ds.

(Signed) J. D. Hennessy M. D. (Coroner.)

May 19, 1920 (Address) 2802 Edgewood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. / ds. State yrs. mos. / ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt Auburn cemetery May 21, 1920

ADDRESS

2500 Broad 1400 Mcelderry St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43355

CERTIFICATE OF DEATH.

D43355

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 W. 29th)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John Russell Higgs

(a) RESIDENCE. NO.

305 W. 29th

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds. How long in U. S., if of foreign birth?

Life

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 30, 1914

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.6420

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Md

10 NAME OF FATHER

John L Higgs11 BIRTHPLACE OF FATHER (city or town)
(State or country)Va

12 MAIDEN NAME OF MOTHER

Myrtle Pettie13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Va

14

Informant
(Address)John L Higgs
305 W. 29th St

15

MAY 21 1920

ROBERT A. LEAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 19 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 18, 1920, to May 19, 1920,that I last saw him alive on May 19, 1920,and that death occurred, on the date stated above, at 10:40 P.m.

The CAUSE OF DEATH* was as follows:

Telomus, resulting from
stroke caused by leg
(duration) yrs. mos. 2 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical Path(Signed) Robt Normant, M. D.(Address) 3547 Chestnut St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Marys Hampden May 22 1920

20 UNDERTAKER

ADDRESS

Chenoweth Len Chestnut St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120D43356

D43356

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3628 Maple Ave ST.; 13 WARD)

2-FULL NAME

Elis Schaffer

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 3628 Maple Ave St.; 20 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

Feb 24, 1837
(Month) (Day) (Year)

7-AGE,

3 yrs., 3 mos., 26 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

9-BIRTHPLACE, (State or Country),

ind

10-NAME OF FATHER,

John Schaffer

11-BIRTHPLACE OF FATHER (State or Country),

ind

12-MAIDEN NAME OF MOTHER

Rebecca Snyder

13-BIRTHPLACE OF MOTHER (State or Country),

ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo H Schaffer

(Address) 3628 Maple Ave

15-

Filed MAY 21 1920

ROBERT R KRAUTER

Bureau of Vital Statistics, City of Baltimore, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1st 1920, to May 20, 1920, that I saw him alive on May 19th 1920, and that death occurred, on the date stated above, at 10:50 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Int Nephritis
(Duration) yrs. mos. ds. 5

CONTRIBUTORY (Secondary)

Chronic Int Nephritis
(Duration) yrs. mos. ds. 5

(Signed) B. A. Schaffer M. D.

May 21, 1920 (Address) 11-27 W. 1st Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Manchester Carroll
20-UNDERTAKERMay 23 1920
ADDRESS

Chenoweth & Co. Chestnut Ave

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43357

PLACE OF DEATH

CITY OF BALTIMORE (No. 343 W 21 st ST. 17 WARD)

2-FULL NAME

(Residence in Baltimore: No. 343 W 21 st ST. 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; (yrs., 5) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

White

5-STATUS
MARRIED, WIDOWED, OR DIVORCED
(Write the word.)
Widower

6-DATE OF BIRTH

Unknown, 1
(Month) (Day) (Year)

7-AGE,

66 yrs. mos. ds.

If LESS than 1 day,
hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Labor 040

9-BIRTHPLACE,
(State or Country).

Ireland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER
(State or Country)

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

James E. Curkle

(Address) 343 W 21 st

15-

MAY 21 1920

Filed 101

LOVEY A KRAUTER

BALTIMORE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry thereon and from the evidence obtained by said Inquest, autopsy or inquiry

and that said deceased came to death on the day stated above.

THE CAUSE OF DEATH was as follows:

Failure of heart
secondary to chronic
hypertension
(arteriosclerosis)
(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Curran M. D.

(Coroner) May 21 1920 (Address) 369 E. Baltimore

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Catherine's Cathedral

May 24 1920

20-UNDERTAKER

Chenoweth & Co. Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43358

156 D43358

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *2741 Huntington Ave* ST.: *19* WARD)
2-FULL NAME *Clara K. Czer*
(Residence in Baltimore: No. *2741 Huntington Ave* St.: (yrs., *2* mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *♀*
4-COLOR OR RACE, *White*
5-STATUS *Married*
6-DATE OF BIRTH, *July 9*, 1888
(Month) (Day) (Year)
7-AGE, *32* yrs. *10* mos. *10* da.
If LESS than 1 day, ...hrs. or ...min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer). *Housewife*

9-BIRTHPLACE, (State or Country), *New York City*
10-NAME OF FATHER, *Unknown*
11-BIRTHPLACE OF FATHER (State or Country), *Unknown*
12-MAIDEN NAME OF MOTHER, *Unknown*
13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Albert J. Czer*
(Address) *2741 Huntington Ave*

15- *MAY 21 1920*
Filed *101*
ROBERT A. KRAUTER
Burial Permitted

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 19*, 19*20*
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* thereon and from the evidence obtained by said *Inquest*, find that said deceased came to death *my* on the day stated above.

The CAUSE OF DEATH was as follows:
Gass. Poison
Suicide
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) *John H. ...*
(Address) *1631 R ...*
State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... da. State ... yrs. ... mos. ... da.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Syracuse, N.Y.*
DATE OF BURIAL, *May 21 1920*
20-UNDERTAKER, *Chenoweth Son*
ADDRESS *Chestnut St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec. 6-3-12—H. P. Co.—1000 Bks.

D43359
140025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43359

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST.: *6th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Jane Cullen*

(a) RESIDENCE. No. *424 N. Broadway* ST. *Baltimore* WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

+

6 DATE OF BIRTH (month, day, and year) *Dec. 23rd 1833*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

86

4

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Philadelphia Pa.

10 NAME OF FATHER

Matthew McClinton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Susan Appleby

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

14

Informant (Address)

J. H. H. Beames

15

Filed

MAY 21 1920

ROBERT E. LEAFTER
Registrar

861st Street

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 19 1920*

17

I HEREBY CERTIFY, That I attended deceased from *April 5th*, 1920, to *May 19*, 1920, that I last saw h. *live* alive on *May 18*, 1920, and that death occurred, on the date stated above, at *8 P.M.* The CAUSE OF DEATH* was as follows:

Smility

(Caus)

(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

CO poisoning

(duration) *1* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

no

Did an operation precede death? *no* Date of

Was there an autopsy? *yes*

What test confirmed diagnosis?

(Signed)

Chas. H. Koon

M. D.

, 19

(Address) *Johns Hopkins*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery

May 22 1920

20 UNDERTAKER

Chas. F. Evans & Son 118 W. Mt. Royal Ave

1. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43360

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

4 * 186 D43360

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *University Hospital* ST.: WARD)

2-FULL NAME *Jos A Keene*

(Residence in Baltimore: No. *Sparrows Point* St.: yrs. mos. *3* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*

4-COLOR OR RACE, *Color S*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)

6-DATE OF BIRTH, *Don't know, 1*
(Month) (Day) (Year)

7-AGE, *34* yrs. mos. ds.
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer), *Laborer*

9-BIRTHPLACE, *live in Balt Sparrows Point*
(State or Country), *Worcester to Cambridge and 2 months*

PARENTS.

10-NAME OF FATHER, *Jos Blazer*

11-BIRTHPLACE OF FATHER, *ms*
(State or Country),

12-MAIDEN NAME OF MOTHER, *Rose Keene*

13-BIRTHPLACE OF MOTHER, *ms*
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm Hester Keene*

(Address) *Worcester Cambridge and*

15-MAY 21 1920

ROBERT E KRAUTER

Filed, 191. BURIAL PLACE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 19, 1920*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)
and that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Popliteal Artery. Bursitis by dirt falling on knee
(Duration) yrs. mos. ds. *3*
CONTRIBUTORY (Secondary) *Accident*
(Duration) yrs. mos. ds. *3*
(Signed) *J H Gorman* M. D.
(Coroner.)
5121, 1912 Address *1725 W Saratoga*
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).
At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence *Cambridge, Mass*
19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,
Cambridge Am Worcester *21*, 1920.
20-UNDERTAKER, ADDRESS *1725-*
Wm R A Elliot *Ashland St*

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D43361

CERTIFICATE OF DEATH.

79 D43361

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 Clifton Ave ST.: 13 WARD)

2-FULL NAME

Mary Harb-Zell

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

1613 Clifton Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofCharles Harb-Zell

6 DATE OF BIRTH (month, day, and year)

Mar 8 / 1858

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.616

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore

10 NAME OF FATHER

Michael A. Leary

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Katherine McCullough

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant
(Address)Mrs. Anna Leary
308 E. Howard St.

15

MAY 21 1920ROBERT A. KRAUTER

Registrar

Burial Permit 01003

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1920

17

I HEREBY CERTIFY, That I attended deceased from

Sept 1 - , 1919, to May 21 - , 1920.that I last saw her alive on 5 - 19 - , 1920.and that death occurred, on the date stated above, at 22 m.

The CAUSE OF DEATH* was as follows:

Crohn's DiseaseCONTRIBUTORY (Secondary) Acute Hypertension
(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. Brown M. D.Address 1928 N. Bolton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Green ParkMay 24 1920

20 UNDERTAKER

John Corbett

ADDRESS

408 S. M. Ave

PLACE OF DEATH in plain terms, so that it may be properly classified. Example: OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

043362

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Church Home and Infirmary*
CITY OF BALTIMORE: (No. *26 N. Broadway* ST. *3* WARD)
2-FULL NAME *Mrs. Charlotte Prader*
(a) RESIDENCE. No. *612 S. Broadway* ST. *43* WARD. *3*
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred *43* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. *109 043362*
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Albert Prader*

6 DATE OF BIRTH (month, day, and year) *March 19-1857*

7 AGE Years *63* Months *2* Days *—* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

May 21 1920

ROBERT E. BLANTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 19 1920*

17

I HEREBY CERTIFY, That I attended deceased from *May 18*, 19*20*, to *May 19*, 19*20*,

that I last saw her alive on *May 19*, 19*20*,

and that death occurred, on the date stated above, at *8:15 P. m.*

The CAUSE OF DEATH* was as follows:

Umbilical Hernia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *May 14-1920*

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Walter S. Anderson* M. D.

, 19 (Address) *Church Home & Infirmary*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Evangelical Sem.

May 23 1920

20 UNDERTAKER

ADDRESS

H. Lander Lewis

1210 Pearl St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43363

CERTIFICATE OF DEATH.

64 D43363

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2748 Lively ave ST. 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Frederick Leuthecker

(Residence in Baltimore: No. 2748 Lively ave

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single

6-DATE OF BIRTH, May 18, 1867 (Month) (Day) (Year)

7-AGE, 53 yrs. 1 mos. 1 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Retired Merchant (b) General nature of industry, business, or establishment in which employed (or employer). Merchant

9-BIRTHPLACE, (State or Country), Baltimore Md

10-NAME OF FATHER, John Leuthecker

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Louisa Schaefer

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Minnie Leuthecker

(Address) 2748 Lively ave

15- MAY 21 1920 101. ROBERT E. EKAUTER

Burial place

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 19, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 17, 1920, to May 19, 1920, that I saw him alive on May 17, 1920, and that death occurred, on the date stated above, at 5:30 P. M. The CAUSE OF DEATH* was as follows:

(Paralysis - 3rd stroke)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration) yrs. mos. ds.

(Signed) J. H. Coppage M. D.

May 20 1920 (Address) 2323 N. Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

St. Pauls Church, May 22, 1920

20-UNDERTAKER ADDRESS

H. Vander Louw 1701 E. St.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D43364

D43364

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 2219 Mondawmin St.)

WARD 3

FULL NAME

Frederick W. Meier

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2219 Mondawmin St.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widower

6-DATE OF BIRTH May 31, 1899 (Month) (Day) (Year)

7-AGE 80 yrs. 11 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Tailor (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Germany

10-NAME OF FATHER Martin

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Martin

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Meier

(Address)

2219 Mondawmin St.

15 MAY 21 1920

ROBERT B. EBAUTER

Filed

191

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 20, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 12, 1920, to May 20, 1920.

that I saw him alive on May 20, 1920.

and that death occurred, on the date stated above, at 6:20 P. M.

The CAUSE OF DEATH* was as follows:

Coronal

Contributory (SECONDARY) Cerebral Hemorrhage (Duration) yrs. mos. 5 ds.

(Signed) Dr. Bruch Joyce M. D. (Address) 1800 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Baltimore Cem

DATE OF BURIAL

May 22, 1920

20-UNDERTAKER

W. L. Lichman

ADDRESS

1000 N. E. St.

D43365

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43365

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3902 Harrison Ave ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 3902 Harrison Ave St.; 70 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Married

6-DATE OF BIRTH,

....., 1850
(Month) (Day) (Year)

7-AGE,

70 yrs. mos. ds.

If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

House wife
0379-BIRTHPLACE,
(State or Country),

Ireland

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER
(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Bridget Molloy

13-BIRTHPLACE OF MOTHER
(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert P. Harrison(Address) 3902 Harrison Ave

15-

Robert P. Harrison,

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 18, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
May 15 1920, to May 18 1920,
that I saw her alive on May 18 1920,
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:Chronic Myocarditis
with Arteriosclerosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY
(Secondary)Pulmonary Embolism
Subacute

(Duration) 7 yrs. mos. ds.

(Signed) J. H. Jones M. D.5/19, 1920 (Address) 804 Calhoun St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Lorraine

DATE OF BURIAL,

May 22, 1920

20-UNDERTAKER

Martin Fahy & Sons 1827 W North Ave

is very important. See instructions on back of certificate.

MAY 21 1920

D43366

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43366

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.: *2* WARD)

2-FULL NAME

Alice Lovewenson

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

2015 Eutan Place ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

N

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 14-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Mercy Hospital

10 NAME OF FATHER

Albert B. Lovewenson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Richmond Va.

12 MAIDEN NAME OF MOTHER

Carlyn Hauiline

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Robert I. ...

15

*MAY 21 1920**Burial Permit Book*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 21 1920

17

I HEREBY CERTIFY, That I attended deceased from

*May 15, 1920, to May 21, 1920*that I last saw her alive on *May 21, 1920*and that death occurred, on the date stated above, at *2:30 P. M.*

The CAUSE OF DEATH* was as follows:

Infantile Peritonitis
Pulmonary Embolism(duration) yrs. mos. *7* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *3* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Smear blood - leukocytes*(Signed) *J. W. ...* M. D., 19 (Address) *Mercy Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Staten Island *May 21 1920*

20 UNDERTAKER

ADDRESS

Edward ...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43367

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43367

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Flack(a) RESIDENCE. No. 1125 Hollins St.

ST. _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

Female

White

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1892

7 AGE

Years

Months

Days

If LESS than
1 day. hrs.
or min.

28

OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Housework

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore, Md.
(State or country)10 NAME OF FATHER Omen McUlgann.11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)12 MAIDEN NAME OF MOTHER Mary Firney13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Md.

14

Informant Hospital Records(Address) New City Hospital.

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20, 1920

17

I HEREBY CERTIFY, That I attended deceased from
May 17, 1920, to May 20, 1920.that I last saw her alive on May 19, 1920.and that death occurred, on the date stated above, at 5:10 A. m.

The CAUSE OF DEATH* was as follows:

Chorea;(duration) 2 yrs. mos. ds.CONTRIBUTORY
(Secondary)Pregnancy & Abortion

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No special test(Signed) J. P. Russell, M. D.19 PLACE OF BURIAL, CREMATION OR REMOVAL New City Hospital.*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cem5/21/20

20 UNDERTAKER

ADDRESS

For A. J. Taylor FultonV. J. TaylorStatement of OCCUPA-
tion is verified by
properly classified. Exact
certificates.

AY 21 1920

DEPARTMENT OF CHARITIES AND CORRECTIONS
SUB-DEPARTMENT
SUPERVISORS OF CITY CHARITIES

LAMAR HOLLYDAY,
SUPERINTENDENT

W. H. CURRY,
PURVEYOR



BAY VIEW HOSPITAL , May 22, 1920
HIGHLANDTOWN P. O.

Dr. C. Hampton Jones.
City Health Department.
Baltimore, Md.

Dear Doctor,

Mrs. Margaret Flack, who entered our hospital on May 17, 1920 and died May 20, 1920 was signed out, on the death certificate as "Chorea" for primary cause and "Pregnancy with abortion" as complicating cause.

I wish to make an additional statement that the abortion was ^{ONE} spontaneous about two hours before her death.

Very truly yours,

J. Hessel

Resident Physician.

J/F/P/--M/H

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43368

D43368

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Little Sisters of the Poor

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Kate Johnson

(Residence in Baltimore: No.

Little Sisters of the Poor

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Old

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word.)
Wid

6-DATE OF BIRTH,

March, 1855

(Month)

(Day)

(Year)

7-AGE,

65 yrs. 2 mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE,
(State or Country),

Baltimore Md.

10-NAME OF FATHER,

Jeremiah C. Kaplan

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

Alice Alice Dennis

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Sister Benedict

(Address)

Little Sisters of the Poor

15-

MAY 21 1920

Robert P. Harrison

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 21, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I saw her alive on May 17, 191

and that death occurred, on the date stated above, at 9 am.

The CAUSE OF DEATH* was as follows:

White Leucemia
1 week (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(Signed) J. A. Warner M. D.
May 21, 1920 (Address) 1133 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cathedral May 22, 1920

20-UNDERTAKER ADDRESS

H. C. Wilderfeld 914 Green St.

Burial Death Book.

D43369

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43369

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Aged Women Home* ST. *19* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1400 W Lexington* St. *So* yrs. *2* mos. *21* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

*W*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Mar*

6-DATE OF BIRTH

Feb 27, 1920
(Month) (Day) (Year)

7-AGE

So 2 21
yrs. mos. ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Balto

10-NAME OF FATHER,

Thos Blundige

11-BIRTHPLACE OF FATHER (State or Country),

Pittsburgh Pa

12-MAIDEN NAME OF MOTHER

Ann Hardester

13-BIRTHPLACE OF MOTHER (State or Country),

Lucas Ave G Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ella J. Jones

(Address)

1404 W Lexington

15-

MAY 21 1920

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 1, 1920, to *May 21, 1920*,that I saw him alive on *May 20, 1920*,and that death occurred, on the date stated above, at *7:30 A* m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

May 21, 1920 (Address) *939 N Fayette*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? *at the Home*

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Mount Olivet Cemetery

DATE OF BURIAL,

May 21 1920

20-UNDERTAKER

Wm J Pratt

ADDRESS

10006

HEALTH DEPARTMENT--CITY OF BALTIMORE

D43370

CERTIFICATE OF DEATH.

D43370

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *6 W. Cross*ST.: *23* WARD)

2-FULL NAME

Michael Zinkand

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. *6 W. Cross*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

48 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Annie Zinkand*

6 DATE OF BIRTH (month, day, and year)

Aug. 30 1871

7 AGE

Years

Months

Days

If LESS than
1 day, ... hrs.
or ... min.*48**8**19*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

017

(c) Name of employer

*Krauss & Co.*9 BIRTHPLACE (city or town)
(State or country)*Baltimore Md.*

10 NAME OF FATHER

*Hugo Zinkand*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Germany*

12 MAIDEN NAME OF MOTHER

*Elasha Miller*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Germany*

14

Informant
(Address)*Annie Zinkand*

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 19 1920

17

I HEREBY CERTIFY, That I attended death from

*May 18th 1920 to May 19th 1920*that I last saw him alive on *May 18th 1920*and that death occurred, on the date stated above, at *3 A. M.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)(duration) *1* yrs. *1* mos. *1* ds.CONTRIBUTORY
(Secondary)(duration) *1* yrs. *1* mos. *1* ds.

18 Where was disease contracted

if not at place of death?

at place of death

Did an operation precede death?

No Date of *7*

Was there an autopsy?

No

What test confirmed diagnosis?

Physical Examination

(Signed)

Harry Weibel M. D.1920 (Address) *1217 1/2 Anson St Balto.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Cross A.C.C.**May 22 1920*

20 UNDERTAKER

ADDRESS

*E. & B. Harle**115 E. West St*

MAY 21 1920

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43371

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43371

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2863 Woodbrook St. WARD) 3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Bessie Hohmann(a) RESIDENCE. No. 2863 Woodbrook St. WARD. Pleasant Hill Md.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

1 mo.

ds.

How long in U. S., if of foreign birth? Life yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofJ. Adam Hohmann

6 DATE OF BIRTH (month, day, and year)

July 2, 1885

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

34 10 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stone

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co Md
(State or country)

10 NAME OF FATHER

Ephraim Hallonee

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Co. Md

12 MAIDEN NAME OF MOTHER

Mary A. Ambrose

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Co. Md

14

Informant
(Address)J. Adam Hohmann
Roslyn Md

15

Filed

19

MAY 21 1920

Robert P. Harrison

Registrar

Burial Permit: Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr 20, 1920, to May 21, 1920.that I last saw him alive on May 20, 1920.and that death occurred, on the date stated above, at 1240 A. M.

The CAUSE OF DEATH* was as follows:

Paraneurystic tubercle(duration) 7 yrs. mos. ds.CONTRIBUTORY
(Secondary)Hypertension(duration) yrs. mos. 30 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Intestine(Signed) A. C. Smith, M. D., 1920 Address 4509 Gilman St. Hgt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Pleasant Hill, Balt Co MdMay 23 1920

20 UNDERTAKER

ADDRESS

Geo W Little531 K Fremont Ave

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43372

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43372

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 Kennedy Ave ST.: 9

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles A. Heiny Sr.

(a) RESIDENCE. NO.

2000 Kennedy Ave ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds. How long in U. S., if of foreign birth?

Life

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Widowed

5a If married, widowed or divorced, HUSBAND of (or) WIFE of

the late Katherine Heiny

6 DATE OF BIRTH (month, day, and year)

July 29-1853

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

66

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Henry J. Heiny

11 BIRTHPLACE OF FATHER (city or town)

Germany

(State or country)

12 MAIDEN NAME OF MOTHER

Annie Weber

13 BIRTHPLACE OF MOTHER (city or town)

Germany

(State or country)

14

Informant

Charles A. Heiny Jr

(Address)

2000 Kennedy Ave

15

Informant

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 19-1920

17

I HEREBY CERTIFY, That I attended deceased from

May 19, 1920, to May 18, 1920,

that I last saw him alive on May 18, 1920,

and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Apoplexy at base of Brain

(duration)

yrs.

mos.

3 hrs

CONTRIBUTORY (Secondary)

ruptured blood vessel in Brain

(duration)

yrs.

mos.

3 hrs

18 Where was disease contracted?

If not at place of death?

2000 Kennedy Ave

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical

(Signed)

James M. Barton

M. D.

5/20/1920 (Address)

700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore

May 23 1920

20 UNDERTAKER

William Cook

ADDRESS

502 E. North Ave

MAY 21 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43373

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2111 E North Ave ST. 8 WARD)

2-FULL NAME

Mary A Kroh

(a) RESIDENCE. NO.

2111 E North Ave ST. 8 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Philip Kroh6 DATE OF BIRTH (month, day, and year) July 18, 18387 AGE Years 81 Months 10 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md (State or country)10 NAME OF FATHER Murray Wheeler11 BIRTHPLACE OF FATHER (city or town) md (State or country)12 MAIDEN NAME OF MOTHER Martina Green13 BIRTHPLACE OF MOTHER (city or town) md (State or country)

14

Informant Clarence Kroh (Address) 2111 E North AveRobert I. ...

Registrar

Partial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19th 192017 I HEREBY CERTIFY, That I attended deceased from May 12th 1920 to May 19th 1920, that I last saw him alive on May 18th 1920, and that death occurred, on the date stated above, at 4 P m. The CAUSE OF DEATH* was as follows:Lobar Pneumonia(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of noWas there an autopsy? no

What test confirmed diagnosis?

(Signed) M. A. Fair M. D.12 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Middleton CemeteryMay 22 1920

20 UNDERTAKER

ADDRESS

E. L. Roy Stiffen25 E North Ave

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 21 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43374

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes Hospital* ST. WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred *32* yrs. mos. ds.How long in U. S., if of foreign birth? *32* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant
(Address)

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 21* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

May 14, 19 *20*, to *May 21*, 19 *20*,that I last saw him alive on *May 21*, 19 *20*,and that death occurred, on the date stated above, at *1:30 P. m.*

The CAUSE OF DEATH* was as follows:

*Broncho pneumonia**3 wks.* (duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *C. L. Parks*, M. D., 19 (Address) *St. Agnes Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral**MAY 25 1920*

20 UNDERTAKER

ADDRESS

*Mr. & Mrs. N. F. Fink**2651 Piedmont*

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY.

D43375

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43375

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland Penitentiary* ST. *10* WARD)

2-FULL NAME

(Residence in Baltimore: No. *Joseph Butler* St.; *10* yrs., *5* mos., *24* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *Black* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single* (Write the word.)

6-DATE OF BIRTH. *November-15, 1901* (Month) (Day) (Year)

7-AGE. *19* yrs., *5* mos., *24* ds. If LESS than 1 day, *hrs.* or *min.*

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Farm* (b) General nature of industry, business, or establishment in which employed (or employer). *Laborer*

9-BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *Thomas Butler*

11-BIRTHPLACE OF FATHER (State or Country), *Maryland*

12-MAIDEN NAME OF MOTHER *Bell Smith*

13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John F. Harrison* (Address) *Maryland Penitentiary*

15- *MAY 22 1920* Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May-9, 1920* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *March-1-1920*, to *May-9-1920*, that I saw him alive on *May-8-1920*, and that death occurred, on the date stated above, at *7:40 a. m.* The CAUSE OF DEATH* was as follows: *over*

Pulmonary Hemorrhage (Duration) *2 1/2* yrs., *24* ds.

CONTRIBUTORY. *General Tuberc.* (Secondary) *loss* (Duration) *2* yrs., *9* mos., *9* ds. (Signed) *William J. Schwartz* M. D. *5/9, 1920* (Address) *Md. Penitentiary*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *2* yrs., *7* mos., *5* ds. In the State *2* yrs., *5* mos., *5* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Lindenstowe, Md.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *MAY 21, 1920*

20-UNDERTAKER ADDRESS

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43376

D43376

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 McCulloh ST.; 14 WARD)

REGISTERED NO. C

2-FULL NAME

Earl Augustus Carter

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1903 McCullohSt.; 1 yrs., 5 mos., 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

February 17, 1919
(Month) (Day) (Year)

7-AGE,

1 yrs., 3 mos., 4 ds.If LESS than 1 day,
....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....9-BIRTHPLACE,
(State or Country),md10-NAME OF
FATHER,John H Carter11-BIRTHPLACE
OF FATHER
(State or Country),md12-MAIDEN NAME
OF MOTHERMable Green13-BIRTHPLACE
OF MOTHER
(State or Country),va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

John H Carter

(Address).....

1903 McCulloh

15-

Robert P. Harris

Filed.....

191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 16, 1920, to May 21, 1920,that I saw him alive on May 20, 1920,and that death occurred, on the date stated above, at 11:30 AM.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous
nephritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....Broncho Pneumonia
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....Edward Short.....M. D.May 21, 1920 (Address) 1812 Druid Hill Ave*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted,
if not at place of death?.....Former or
usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Ambrose Church May 23, 1920

20-UNDERTAKER ADDRESS

Samuel H. Hundy 318 N. B. St.

important. See instructions on back of certificate.

D43377

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43377

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 Mill Race Road WARD 13)2-FULL NAME Charles M. Talbott(a) RESIDENCE. NO. 1504 Mill Race Road WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Lona W. Talbott

6 DATE OF BIRTH (month, day, and year)

Feb 24 1888

7 AGE Years Months Days

39817

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va

10 NAME OF FATHER

John Talbott

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Mary Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant

Lona W. Talbott

(Address)

1504 Mill Race Road

15

Filed

1920

P. Harris

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 19 20

17

I HEREBY CERTIFY, That I attended deceased from

May 14, 19 20, to May 21, 19 20.that I last saw him alive on May 21, 19 20.and that death occurred, on the date stated above, at 3:50 P. m.

The CAUSE OF DEATH* was as follows:

overChronic Pneumonia(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

Gastric Ulcer(duration) yrs. 10 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical Exam & X-rays

(Signed)

Chesley, M. D.

May 22/20 (Address)

3549 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Brownville MdMay 25 1920

20 UNDERTAKER

ADDRESS

Chenoweth SonChesley

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

126 D43378

D43378
1. PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 636 Robt St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Williams

(Residence in Baltimore: No. 636 Robt St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. Brown 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married (Write the word.)

6-DATE OF BIRTH, 1874, 1 (Month) (Day) (Year)

7-AGE. 46 If LESS than 1 day, yrs. mos. ds. hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Laborer (b) General nature of industry, business, or establishment in which employed (or employer). Asphalt

9-BIRTHPLACE, (State or Country), N. C.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw. Williams (Address) 636 Robt St.

15-Filed, 191, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 18, 1912 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15, 1912, to May 18, 1912, that I saw him alive on May 18, 1912, and that death occurred, on the date stated above, at 310. The CAUSE OF DEATH* was as follows:

Pylo-Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pylo-Pneumonia

(Duration) yrs. mos. ds.

(Signed) H. P. Egan M. D.

1912 (Address) 324 North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn

DATE OF BURIAL, May 22, 1912

20-UNDERTAKER, Daniel Egan

ADDRESS, 316

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43379

CERTIFICATE OF DEATH.

28 D43379

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 n Eutaw ST.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Annie Stephens(Residence in Baltimore: No. 930 n EutawSt.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ♀ 4-COLOR OR RACE, negro 5-SINGLE, Single
~~MARRIED~~
~~WIDOWED~~
~~OR DIVORCED~~
(Write the word.)6-DATE OF BIRTH. ? ? 1897
(Month) (Day) (Year)7-AGE. 23 ? ? ?
..... yrs. mos. ds. If LESS than 1 day,
..... hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), S. C.10-NAME OF FATHER, Levey Stephens11-BIRTHPLACE OF FATHER (State or Country), S. C.12-MAIDEN NAME OF MOTHER Eura Gammons13-BIRTHPLACE OF MOTHER (State or Country), S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Olliver Stephens(Address) 930 n. Eutaw

15-

Filed MAY 22 1920 101. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 20, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from April 15 1920, to May 20 1920, that I saw her alive on May 20 1920, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary).....

(Signed) J. McRae M. D.
5721 191. (Address) 739 George

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Racford N. C. May 22 1920

20-UNDERTAKER ADDRESS

Daniel E. Egan Racford N. C.

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43380

D43380

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1213 Light* ST.; *23* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1213 Light St.* St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED, *married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

5 *19*, *1920*
(Month) (Day) (Year)

7-AGE,

.....yrs.....mos.....ds.

If LESS than 1 day,
.....hrs. or.....min.

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....*none*
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....*000*9-BIRTHPLACE,
(State or Country),10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country),12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *McK Pamos*(Address) *2101 Panna an*

15-

MAY 22 1920

Robert P. Harrison

191.....
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5 - *20*, - *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

5/19 19*20*, to *5/20* 19*20*,that I saw him alive on *5/20/20* 19*20*,and that death occurred, on the date stated above, at *2 a.m.*

The CAUSE OF DEATH* was as follows:

Premature birth -

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) *James Brown Jr.* M. D.*5/20/20* (Address) *1213 Light St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

*Woodlawn Cemetery**May 22 1920*

20-UNDERTAKER

ADDRESS

*Daniel Easton**8 am*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43381

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 146 Kenwood ave

ST. 26 WARD)

REGISTERED NO. C

2-FULL NAME

Dominic Zelenka

(Residence in Baltimore: No.

146 Kenwood ave

St.; 20 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH,

Not known

(Month)

(Day)

(Year)

7-AGE,

60

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Tailor

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Bohemia

10-NAME OF FATHER,

Vincent Zelenka

11-BIRTHPLACE OF FATHER
(State or Country),

Bohemia

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER
(State or Country),

Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Anna Zelenka

(Address)

146 Kenwood ave

15-

Filed

191

Registrar.

AY 22 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 20 1920, 191...
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1920, to May 20 1920,

that I saw him alive on May 20 1920,

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Carbuncle

(Duration) yrs. mos. ds.

CONTRIBUTORY...Septic Endocarditis....
(Secondary)

(Duration) yrs. mos. ds.

(Signed) William J. Ryan, M. D.

May 20, 1920 (Address) 801 N. Kenwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Hill

DATE OF BURIAL,

May 22, 1920

20-UNDERTAKER

Frank Jackson

ADDRESS

Not known

STATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43382

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43382

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Hopkins Hospital*)

WARD

2-FULL NAME

(Residence in Baltimore: No. *Laliole Apt*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH

Oct 1st 1881
(Month) (Day) (Year)

7-AGE

38 yrs. *7* mos. *10* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Secretary*
(b) General nature of industry, business, or establishment in which employed (or employer). *Contractor*

9-BIRTHPLACE, (State or Country)

Mathews Co Va.

10-NAME OF FATHER

John Diggs White

11-BIRTHPLACE OF FATHER (State or Country)

Mathews Co Va.

12-MAIDEN NAME OF MOTHER

Lizzie Hodgins

13-BIRTHPLACE OF MOTHER (State or Country)

Mathews Co Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. D. Foster

(Address)

221 N. Calvert St

15-

Robert P. Harrison

Filed *2-2-1920*

191

Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 21 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest find that said deceased came to death (Inquest, au-

topsy or inquiry.) on the day stated above. The CAUSE OF DEATH* was as follows:

Suicide by self-harm

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner)

W. F. Slater M. D.
5-21, 191.20 Address

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bolton and Mathews St

May 21 1920

20-UNDERTAKER

ADDRESS

Henry H. Jenkins

McClulloh Orchard St

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43383

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43383

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 322 - 22 1/2 St. 12 WARD)

2-FULL NAME

(Residence in Baltimore: No. 322 - 22 1/2 St.; yrs., mos. 7 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

It LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Caroline Montague

(Address) 322 - 22 1/2 St.

15-

Filed

Robert P. Harrison

191

Burial Permit of Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Harrison M. D.

(Coroner)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43384

CERTIFICATE OF DEATH.

REGISTERED NO.

D43384

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2012 E. Eager ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sarah E. Tully

(a) RESIDENCE. No. 2012 E. Eager ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

Charles E. Tully

6 DATE OF BIRTH (month, day, and year)

Jan 23, 1847

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

72

3

27

8 OCCUPATION OF DECEASED

at home

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Mr. Chester

11 BIRTHPLACE OF FATHER (city or town) (State or country)

England

12 MAIDEN NAME OF MOTHER

Martha Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

14

Informant (Address)

Charles E. Tully
2012 E. Eager

15

Filed

Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 20, 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 1, 1919, to May 20, 1920

that I last saw him alive on May 19, 1920

and that death occurred, on the date stated above, at 2:15 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Sacc Bladder

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

19 (Address) 1823 N. East St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount

May 24 1920

20 UNDERTAKER

Zirkler & Zirkler

ADDRESS

1739 Eager

TION is very important. See instructions on back of certificates.

D43386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓ D43386
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 S. Ann St ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 15 S. Ann St ST. V WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. 5 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single6 DATE OF BIRTH (month, day, and year) Dec. 18 - 19017 AGE Years 18 Months 5 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland10 NAME OF FATHER John Krebs11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md12 MAIDEN NAME OF MOTHER Rosina Goller13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

PARENTS

14 Informant Rosina Krebs (Address) 15 S. Ann St15 Filed Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20, 192017 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1920, to May 20, 1920.that I last saw him alive on May 20, 1920.and that death occurred, on the date stated above, at 5:46 m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? clinically(Signed) A. T. Reis M. D.May 21/1920 (Address) 24 S. 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Most Holy Redeemer May 23 1920

20 UNDERTAKER

ADDRESS

Hendel & Poppel 37 S. Ann St

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 22 1920

Burial Permit 61823

D43387

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43387

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *University Hospital*)ST.: *73* WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1040 S. Sharp St.*)St.: *35* yrs., mos. da.)

PERSON 1. AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Don't Know, *1857*
(Month) (Day) (Year)

7-AGE,

63

yrs. mos. da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Engineer*

9-BIRTHPLACE, (State or Country),

Ireland

PARENTS.

10-NAME OF FATHER,

Don't Know

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Don't Know

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Margaret Flannery*(Address) *1040 S. Sharp St.*

15.

*Robert P. Harrison,*Filed *22* 1920.

191.

Burial Permit Class.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May, *20*, *1920*
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said
(Inquest or autopsy or inquiry.)find that said deceased came to his death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull, due to being struck by automobile
(Duration) yrs. mos. da. *a few hrs.*

CONTRIBUTORY (Secondary)

Accident

(Duration) yrs. mos. da.

(Signed) *M. J. Gorman* M. D.5:22, 1920 (Address) *117 N. Saratoga*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*New Cathedral Cem.**May 23*, 1920

20-UNDERTAKER

ADDRESS

*F. A. France & Son**117 N. Saratoga*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43388

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43388

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Hope(a) RESIDENCE. NO. 1105 Carson Court

(Usual place of abode)

Unknown

ST. _____ WARD. _____

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. _____ mos. _____

ds. _____ How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofRobert Hope6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown9 BIRTHPLACE (city or town)
(State or country)South Carolina

10 NAME OF FATHER

Frank Sterling

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

South Carolina12 MAIDEN NAME OF MOTHER Hattie ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

South Carolina

14

Informant
(Address)Hospital Records
W.T.H.

15

Filed

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20th, 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 17th, 1920, to May 20th, 1920,that I last saw her alive on May 19th, 1920,and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 2 yrs. (?) mos. _____ ds.CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

if not at place of death? UnknownDid an operation precede death? NO Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? T.B. in sputum.(Signed) George H. Wilkinson, M. D.5-20-20 Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Wt AuburnMay 23 1920

20 UNDERTAKER

ADDRESS

Edward Ringgold1463 Mary

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 22 1920

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43389

CERTIFICATE OF DEATH

D43389

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2426 N. Charles ST. 12 WARD)
2-FULL NAME Mateida B. Hall
(Residence in Baltimore: No. 2426 N. Charles St.; 72 yrs. 11 mos. 10 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6-DATE OF BIRTH June 11, 1847
(Month) (Day) (Year)

7-AGE 72 yrs. 11 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work retired
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Balto Md.

10-NAME OF FATHER Robert J. Hall

11-BIRTHPLACE OF FATHER (State or country) Md

12-MAIDEN NAME OF MOTHER Rebecca A. Pull

13-BIRTHPLACE OF MOTHER (State or country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Florence H. Hall
(Address) 2426 N. Charles St.

15-Robert P. Harrison,

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 21st, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 18th, 1920, to May 21st, 1920
that I saw him alive on May 21st, 1920,
and that death occurred, on the date stated above, at 9:20 a.m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus
Appendix
(Duration) yrs. 3 mos. ds.

Contributory (SECONDARY) unknown
(Duration) yrs. mos. ds.
(Signed), Geo. W. Caerney M. D.
May 21st, 1920 (Address) 2112 1/2 St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Md Olivet DATE OF BURIAL May 24, 1920

20-UNDERTAKER John Onitche ADDRESS 2011 W. Fayette

MAY 22 1920

191
Burial Permit

REGISTRAR

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43390

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D43390

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1315 W. Lafayette St. 16 WARD)

2-FULL NAME

Comradel J. Hammond

(Residence in Baltimore: No. 1315 W. Lafayette St. 9 yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Widow

6-DATE OF BIRTH

Sept 8, 1842

7-AGE

77 yrs. 8 mos. 12 ds.

8-OCCUPATION

retired

9-BIRTHPLACE (State or country)

A.A.C. Md

10-NAME OF FATHER

Am Shipley

11-BIRTHPLACE OF FATHER (State or country)

A.A.C. Md

12-MAIDEN NAME OF MOTHER

Sarah Ruthven

13-BIRTHPLACE OF MOTHER (State or country)

A.A.C. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clarence Hammond

(Address)

1315 W. Lafayette St.

15-

Robert P. Harrison,

REGISTRAR

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 20, 1920

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 27, 1920, to May 20, 1920 that I saw her alive on May 20, 1920 and that death occurred, on the date stated above, at 8:30 P. M. The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Contributory (SECONDARY)

Chronic Bronchitis

(Signed)

Dr. J. H. Harrison M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cedar Hill May 22, 1920

20-UNDERTAKER

ADDRESS

John C. Hutchell, 1315 W. Lafayette St.

MAY 22 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43391

CERTIFICATE OF DEATH.

64 D43391

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1343 Carey*)ST.: *15* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *1343 Carey*

(Usual place of abode)

ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *unknown* yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*married*6 DATE OF BIRTH (month, day, and year) *1875*

7 AGE

Years

Months

Days

If LESS than
1 day, ____ hrs.
or ____ min.*45*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labour 040

(b) General nature of industry, business, or establishment in which employed (or employer)

unknown

(c) Name of employer

*unknown*9 BIRTHPLACE (city or town)
(State or country)*Fieldon N.C.*

10 NAME OF FATHER

*unknown*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*N.C.*

12 MAIDEN NAME OF MOTHER

*unknown*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*unknown*

14

Informant
(Address)*Eliza Cobb
1343 N. Carey St.*

15

Filed

19

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/20* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

5/2, 19 *20*, to *5/20*, 19 *20*.that I last saw him alive on *5/20*, 19 *20*.and that death occurred, on the date stated above, at *11:00 A* m.

The CAUSE OF DEATH* was as follows:

*Cerebral apoplexy
(Acute Sclerosis)*(duration) ____ yrs. ____ mos. *20* ds.CONTRIBUTORY
(Secondary)(duration) ____ yrs. ____ mos. *2* ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Buck Hitt*, M. D., 19 (Address) *239 Dumbell*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Not Auburn**May 20 1920*

20 UNDERTAKER

ADDRESS

Edward Ringgold 1463 N. Carey

MAY 22 1920 Burial Permit Clerk.

This is very important. See instructions on back of certificates.

D43392

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43392

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. _____

ST.: _____

WARD) _____

REGISTERED NO. C _____

2-FULL NAME

Leroy Brown

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. _____

St. Elizabeth's Home

St.: _____ yrs. _____ mos. _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

Black

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Not obtained (Month) _____ (Day) _____ (Year) _____

7-AGE,

1 yrs. 10 mos. _____ ds.

If LESS than 1 day,
_____ hrs. or _____ min.

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work _____
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer) _____

9-BIRTHPLACE,

(State or Country), committed to St. Elizabeth's Home
by Bow-Letterington & Co.10-NAME OF
FATHER,

Not obtained

11-BIRTHPLACE
OF FATHER

(State or Country),

12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) _____

(Address) _____

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 21 191²⁰ (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 191²⁰, to May 191²⁰,that I saw him alive on May 20 191²⁰,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

Laryngismus Stridulus

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Frank J. [Signature] M. D.
May 21, 191²⁰ (Address) 2605 E. Monument St.*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-
SIENTS, OR RECENT RESIDENTS).

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
if not at place of death? _____Former or
usual residence _____

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

UNIVERSITY OF MARYLAND May 22, 191²⁰

20-UNDERTAKER

ADDRESS

Commissioner of Health
For City Burial

Important. See instructions on back of certificate.

MAY 22 1920

Robert P. Harrison

Burial Permit Clerk
Registrar.

D43393

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43393

1-PLACE OF DEATH

CITY OF BALTIMORE, NO.

ST.; WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-STATUS,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH

April 29, 1860

7-AGE

60 yrs. 21 mos. ds.

If LESS than 1 day,
hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

9-BIRTHPLACE,

(State or Country).

Baltimore County.

PARENTS.

10-NAME OF FATHER

George C. Hess

11-BIRTHPLACE OF FATHER
(State or Country)

Baltimore County.

12-MAIDEN NAME OF MOTHER

Idette Constantine

13-BIRTHPLACE OF MOTHER
(State or Country).

Baltimore County.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

Mr. John F. Myers
1927 N. Castle St.

15-

Filed. 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 19, 1920

17-I HEREBY CERTIFY, That I attended deceased from

May 7, 1920 to May 19, 1920

that I saw her alive on May 19, 1920, and that death occurred, on the date stated above, at 10:15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 8 yrs. 21 mos. ds.

CONTRIBUTORY (Secondary)

Uremic Coma

(Signed) Albert C. Cusack, M.D.

May 20, 1920 (Address) 2027 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

Landon Park Cemetery

May 22, 1920

20-UNDERTAKER

ADDRESS

George F. Ruth

1735 Hayford Ave.

D43394

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43394

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 S Durham ST.: V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 5 1905

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

15

3

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

16 NAME OF FATHER

Wladyslaw Szymanski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Anna Bochnawick

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Wladyslaw Szymanski
303 S Durham

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 21 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 9, 1920, to May 21, 1920,

that I last saw her alive on May 21, 1920,

and that death occurred, on the date stated above, at 11:20 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. Fred Russell, M. D.

Address

800 V Palomar

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary Cemetery

May 24 1920

20 UNDERTAKER

ADDRESS

John M. Weber

1803 Bank St

Burial Permit Clerk.

should state
Exact statement of
UPA-
TION is very important. See instructions on back of certificates.

MAY 22 1920

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43395

HEALTH DEPARTMENT-CITY OF BALTIMORE

D43395

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST. 15 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Robert P. Harrison,

Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed), M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-BURIAL

ADDRESS

MAY 22 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43396
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2636 E. Baltimore

ST.: 6 WARD)

2-FULL NAME Sarah W. Cox

(a) RESIDENCE. No. 2636 E. Baltimore
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of Edward C. Cox (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 1 1842

7 AGE Years 78 Months 2 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Fairmount (State or country) Somerset Co. Md.

10 NAME OF FATHER George Leach

11 BIRTHPLACE OF FATHER (city or town) Somerset Co. Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary J. Maddox

13 BIRTHPLACE OF MOTHER (city or town) Somerset Co. Md. (State or country)

14 Informant Franklin E. Cox. (Address) 2636 E. Baltimore St.

15 MAY 23 1920 ROBERT F. LAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1920, to May 22, 1920, that I last saw her alive on May 22, 1920, and that death occurred, on the date stated above, at 9.45 P.M. The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

CONTRIBUTORY (Secondary)

(duration) 4 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Meyer, Jr. M. D.

5/19/20 Address 76 38 Britts. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Fairmount Md

DATE OF BURIAL

May 23 1920

20 UNDERTAKER

John F. Denney

ADDRESS

715 Light St

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43397

CERTIFICATE OF DEATH.

150
D43397
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 29. B 11th ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 29 B 11th St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male
4-COLOR OR RACE: White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Jan 2 1920
(Month) (Day) (Year)

7-AGE, 4 yrs. 2 mos. 2 ds.
If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, Frank Cymbor

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Dominica Pronk

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Cymbor

(Address) 29 S. 11th St.

15-

MAY 23 1920

ROBERT H. EBAUTER

BALTIMORE CITY CLERK

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 22 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from May 1 1920, to May 1920, that I saw him alive on May 1920, and that death occurred, on the date stated above, at 3 P. m. The CAUSE OF DEATH* was as follows:

Acute Valvular Heart Disease
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Signed) William J. R. South D.
May 22 1920 (Address) 801 N. Kennerly

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

1st Evangelical 5/23/20

UNDERTAKER, ADDRESS

William Gallop 4141 Eastern

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43398

CERTIFICATE OF DEATH.

D43398

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

Caucasian

5-SINGLE

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

June 30, 1917
(Month) (Day) (Year)

7-AGE,

10 yrs. 10 mos. 20 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,
(State or Country),

Baltimore, Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed....., 191

MAY 23 1920

ROBERT B. TRAUTER

Burial Place

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY That I attended deceased from May 17, 1920, to May 20, 1920, that I saw him alive on May 17, 1920, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Pyelo-nephritis

CONTRIBUTORY
(Secondary)

No contributory

(Signed) H. E. Jones M. D.

20, 1920 (Address) 724 N. York St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Int. Auburn Cemetery May 23, 1920

20-UNDERTAKER

ADDRESS

George H. Holland 1631 Kenning Hill Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D43399

CERTIFICATE OF DEATH.

79 D43399

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin and Fulton* ST. *70* WARD)2-FULL NAME *Martha A. Robey*(a) RESIDENCE. NO. *Home of aged Franklin Fulton* ST. *70* WARD *10*

(Usual place of abode)

Length of residence in city or town where death occurred *70* yrs. *10* mos. *19* ds.

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? *76* yrs. *10* mos. *19* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *♂*4 COLOR OR RACE *W.*5 Single, Married, Widowed, or Divorced (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mr. Robey*6 DATE OF BIRTH (month, day, and year) *July 3 1843*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *76* *10* *19*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. *None*(b) General nature of industry, business, or establishment in which employed (or employer) *—*(c) Name of employer *—*9 BIRTHPLACE (city or town) *Baltimore* (State or country)10 NAME OF FATHER *Michael Gerbrich*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country)12 MAIDEN NAME OF MOTHER *Mary Fugate*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country)

14

Informant (Address) *Mr. J. A. Bowles*
11 E. Pratt St. 11

15

*MAY 23 1920**ROBERT B. BRADY*
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 22 1920*

17

I HEREBY CERTIFY, That I attended deceased from *May 1 - 1920*, to *May 22 1920*, that I last saw her alive on *May 21 1920*, and that death occurred, on the date stated above, at *8:40 P. M.*

The CAUSE OF DEATH* was as follows:

Complications due to age.
Myocarditis and general degenerative changes(duration) yrs. *2* mos. *—* ds.CONTRIBUTORY *Acute heart failure.* (Secondary)(duration) yrs. *—* mos. *1* ds.18 Where was disease contracted *—*

If not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *Abner C. Cole*, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*David Redge**May 24 1920*

20 UNDERTAKER

ADDRESS

*George Smith**1000 W. Gay St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43400

CERTIFICATE OF DEATH.

D43400

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1039 N. Calvert

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Jackson Lee Penn

(a) RESIDENCE

NO. Warabachie Texas

ST.

WARD

Warabachie Texas

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

- yrs.

- mos.

57

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 16 1871

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

49

1

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Texas

10 NAME OF FATHER

Gable J. Penn

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Susan Penn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant (Address)

G. L. Penn

15

MAY 23 1920

ROBERT I. HARTER

Bureau of Health

20 UNDERTAKER

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Warabachie Texas

May 24 1920

20 UNDERTAKER

Henry H. Jenkins

ADDRESS

McCollister

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 Where was disease contracted

If not at place of death?

Warabachie Texas

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Urine blood etc etc

(Signed)

Ernest S. Cross

M. D.

, 19

(Address)

1035 N. Calvert St.

16 DATE OF DEATH (month, day, and year)

May 23 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 29, 1920, to May 23, 1920,

that I last saw him alive on May 23, 1920,

and that death occurred, on the date stated above, at 6:30 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) 2-3

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

arterio-sclerosis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Warabachie Texas

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Urine blood etc etc

(Signed)

Ernest S. Cross

M. D.

, 19

(Address)

1035 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Drechsler.
HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D43401E

D43401E

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7724 N. Charles ST.: 12 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 1709 N. Carroll ST., WARD. Deep Park

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mrs. Clara Drechsler

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

about 55

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

MAY 20 1920

ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1918, to May 21, 1920, that I last saw him alive on May 21, 1920, and that death occurred, on the date stated above, at 1:45 p.m.

The CAUSE OF DEATH* was as follows:

Hepatic

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D43402

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D43402

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 N. Calumet Ave ST.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bert George Stierman(a) RESIDENCE. NO. 622 N. Calumet ST., 7 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofRena Stierman6 DATE OF BIRTH (month, day, and year) Feb 23 / 18827 AGE Years 38 Months 2 Days 25 If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Printer 63

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Phil Pa.
(State or country)10 NAME OF FATHER John Stierman11 BIRTHPLACE OF FATHER (city or town) H. J.
(State or country)12 MAIDEN NAME OF MOTHER Lillian Kirk13 BIRTHPLACE OF MOTHER (city or town) Phil
(State or country)

14

Informant
(Address)Lillian Kirk
622 N. Calumet Ave

15

MAY 23 1920

ROBERT E. KRAMER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 22, 1919, to May 22, 1920that I last saw him alive on May 22, 1920.and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) 1 yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

Ernest S. Passagno M. D.5-22, 1920 (Address) 2314 E. Bulte St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

PhiladelphMay 25 1920

20 UNDERTAKER

ADDRESS

Wm Cork4 + 8 Ave

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43403

CERTIFICATE OF DEATH.

D43403

1-PLACE OF DEATH

1913 E. Lenoval St.

REGISTERED NO.

CITY OF BALTIMORE: (No.)

1913 E. Lenoval

ST.: 8

WARD)

2-FULL NAME

Alice A. Batts

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

1913 E. Lenoval

ST.: 8

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Isaac Batts

6 DATE OF BIRTH (month, day, and year)

Aug 20 1854

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

65

9

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home 31

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Durham, N. C.

10 NAME OF FATHER

William Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Isaac A. Batts
1913 E. Lenoval

15

MAY 23 1920

ROBERT E. LAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 21 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 14, 1920, to May 20, 1920,

that I last saw her alive on May 20, 1920,

and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Stenosis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. McDonald, M. D.

Address 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Ferryman Mds

May 24 1920

20 UNDERTAKER

ADDRESS

W. C. Cook

A. G. W.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43404

CERTIFICATE OF DEATH.

91-089 ✓
D43404
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2823 Hudson ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2823 Hudson

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *M* 4-COLOR OR RACE, *W* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *S.*

6-DATE OF BIRTH, *March 1, 1920*
(Month) (Day) (Year)

7-AGE, *2 yrs. 22 mos. 22 ds.* If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *MD*

10-NAME OF FATHER, *Martin Mullane*

11-BIRTHPLACE OF FATHER (State or Country), *MD*

12-MAIDEN NAME OF MOTHER, *Joan Czarky*

13-BIRTHPLACE OF MOTHER (State or Country), *MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Martin Mullane*(Address) *2823 Hudson*

MAY 23 1920

ROBERT E. LEBLANC

Filed. 191. Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 22, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 22, 1920*, to *May 22, 1920*, that I saw him alive on *May 22, 1920*, and that death occurred, on the date stated above, at *11 a.m.*

The CAUSE OF DEATH* was as follows:

Broncho pneumonia(Duration) yrs. mos. ds. *3*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. *1*(Signed) *Leo Karkusky, M.D.**May 22, 1920* (Address) *3035 Odumell*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Stanislaus*DATE OF BURIAL, *May 24, 1920*20-UNDERTAKER, *Stephen J. Fiackowski*ADDRESS, *1000 S. Kennerly*

D43405

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 91 D43405

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 N. Spring

ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna G. Lloyd

(a) RESIDENCE. No. 225 N. Spring

ST.: 5 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John G. Lloyd.

6 DATE OF BIRTH (month, day, and year) February

7 AGE Years 33 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balti. (State or country) Md.

10 NAME OF FATHER Stephen James

11 BIRTHPLACE OF FATHER (city or town) Balti. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary T. James

13 BIRTHPLACE OF MOTHER (city or town) Balti. (State or country) Md.

14 Informant (Address) John G. Lloyd 225 N. Spring St.

15 MAY 23 1920 ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20, 1920

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1920, to May 20, 1920, that I last saw her alive on May 20, 1920, and that death occurred, on the date stated above, at 5-50 P. M. The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

5-21-1920 (Address) 120 1/2 Reisterstown Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Crescent Hill

5/24/20

20 UNDERTAKER

ADDRESS

Thos White

113 S. Wolfe

D43406

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43406

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *729 S. Third St.* ST.: *26* WARD)

2-FULL NAME

Lawrence F. Lutz.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. *729 S. Third* ST. *26* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 5-1918*7 AGE Years *1* Months *11* Days *16* If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md.*10 NAME OF FATHER *Frank Lutz*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baden Germany*12 MAIDEN NAME OF MOTHER *Elizabeth Zutter*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baran's Germany*

PARENTS

14 Informant (Address) *Frank Lutz 729 S. Third St.*

MAY 23 1920

ROBERT A. BRADY Registrar
Burial Permit 01617

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 21 1920*17 I HEREBY CERTIFY, That I attended deceased from *May 5*, 19*20*, to *May 21*, 19*20*, that I last saw him alive on *May 20*, 19*20*, and that death occurred, on the date stated above, at *7:30 P.* m.

The CAUSE OF DEATH* was as follows:

*Chronic Hydrocephalus*CONTRIBUTORY (Secondary) *Pneumonia* (duration) yrs. *11* mos. *20* ds.(duration) yrs. mos. ds. *21*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *W. J. McAnoy* M. D.Address *839 S. Ellwood Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Sacred Heart Cem.

DATE OF BURIAL

May 24 1920

20 UNDERTAKER

Lilly & Zuler.

ADDRESS

4038 W. 1st St.

Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Alexandra Bielak
HEALTH DEPARTMENT—CITY OF BALTIMORE

D43407

CERTIFICATE OF DEATH.

X 92-0102
V

D43407

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 104 P. Waller St.)
2-FULL NAME Alexandra Bielak
(Residence in Baltimore: No. 104 P. Waller St.)
REGISTERED No. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)
St.; yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female	4-COLOR OR RACE. White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married
6-DATE OF BIRTH. May 1, 1892 (Month) (Day) (Year)		
7-AGE. 28 yrs. 20 mos. ds. If LESS than 1 day, hrs. or min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Stenographer		
9-BIRTHPLACE. (State or Country). Austria		
PARENTS.	10-NAME OF FATHER. Domenic Bielak	
	11-BIRTHPLACE OF FATHER. (State or Country). Austria	
	12-MAIDEN NAME OF MOTHER. Dankman	
	13-BIRTHPLACE OF MOTHER. (State or Country). Austria	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Stanislaw Bielak
(Address) 104 P. Waller St.

15- MAY 23 1920
Filed 191
ROBERT B. KAUTER
Burial Permitted

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.
May 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Influenza Pneumonia Bilateral
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(Duration) yrs. mos. ds.
(Signed) Henry H. Fuller, M. D. (Coroner)
May 22, 1920 (Address) 1610 E. Bay A

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death, yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence New York

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ADDRESS
St. Mary's Hospital, May 24, 1920
20-UNDERTAKER
Nedell Appel, 37 S. Union St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43408

D43408

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1221 N. Caroline St. WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Giovanni Paparino(Residence in Baltimore: No. 1221 N. Caroline St. 34 yrs., 3 mos., 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH, January 23, 1867
(Month) (Day) (Year)7-AGE, 53 yrs. 3 mos. 29 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retail Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) 4459-BIRTHPLACE, (State or Country), Italy10-NAME OF FATHER, Laboratore Paparino11-BIRTHPLACE OF FATHER (State or Country), Italy12-MAIDEN NAME OF MOTHER Domenucia Pirano13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laboratore Paparino(Address) 1221 N. Caroline St.15- MAY 23 1920 ROBERT E. LAUTREFiler 1 191 BURIAL CLAY

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 22, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 17, 1920, to May 22, 1920, that I saw him alive on May 22, 1920 and that death occurred, on the date stated above, at 8.20 A.M.

The CAUSE OF DEATH* was as follows:

chronic interstitial nephritis
(Duration) 2 yrs., 3 mos., 29 ds.

CONTRIBUTORY (Secondary)

(Signed) Eugene E. Pearson M. D.
5-22-1920, 1920 (Address) 2314 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs., 3 mos., 29 ds. In the State 2 yrs., 3 mos., 29 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem.DATE OF BURIAL, 5-25-192020-UNDERTAKER George J. Puth ADDRESS 1735-1745 Ave.

Important. See instructions on back of certificate.

D43409

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43409

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2522 St. Paul ST.; 12 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2522 St Paul St.; 3 yrs., 3 mos., 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

widowed

6-DATE OF BIRTH,

Aug 23, 1846
(Month) (Day) (Year)

7-AGE,

73 yrs., 9 mos., — ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Minister
018

9-BIRTHPLACE,

(State or Country),

Harrisonburg Va

10-NAME OF FATHER,

J.S. Bell

11-BIRTHPLACE OF FATHER

(State or Country),

Delaware

12-MAIDEN NAME OF MOTHER

Martha Jamison

13-BIRTHPLACE OF MOTHER

(State or Country),

Penn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

A. G. Bell

(Address).

Washington D.C.

15-

Filed

MAY 24 1920

ROBERT B. LAUTER

Bottel-Ferris-Gier
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 9, 1920, to May 23, 1920,that I saw him alive on May 23, 1920,and that death occurred, on the date stated above, at 2:45 p.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
(terminal infection)
(Duration).....yrs.....mos. 14 ds.

CONTRIBUTORY

(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

E. H. Wan
M. D.May 23, 1920. (Address) 1515 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Harrisonburg Va

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Harrisonburg Va

May 24, 1920

20-UNDERTAKER

ADDRESS

John B. Spence, 1325 N. Leaden, &

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43410

CERTIFICATE OF DEATH.

34 D43410

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

U.S. Marine Hospital, Bk. Md.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Spencer D. Nicholson

(a) RESIDENCE. No.

6019 Foster Ave.

Gowans. Md.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

Mrs. Spencer D. Nicholson

6 DATE OF BIRTH (month, day, and year)

7 AGE

30

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk

009

(b) General nature of industry, business, or establishment in which employed (or employer)

unknown

(c) Name of employer

unknown

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Rutha V. Nicholson
6019 Foster Ave. Gowans

15

MAY 24 1920

ROBERT E. FRANKLIN
Registrar

Baltimore Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 22 1920

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1919, to May 22, 1920.

that I last saw him alive on May 21, 1920.

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of kidneys

(duration) 2 yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary)

Tuberculosis of intestines (duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death?

U.S. Army.

Did an operation precede death?

yes

Date of 12-11-19

Was there an autopsy?

no

What test confirmed diagnosis?

Bacteriological tests.

(Signed)

Chas. H. Nagel

M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Woodlawn

DATE OF BURIAL

May 24 1920

20 UNDERTAKER

E. Le Roy Stippler

ADDRESS

125 E. North Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43411

D43411

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 Collins Ave ST. 9th WARD)

2-FULL NAME

(a) RESIDENCE. NO. 132 Collins Ave ST. 9th WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 20, 1920

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

James S. McNulty

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Emmitsburg Md

12 MAIDEN NAME OF MOTHER

Ethel Opie

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Baltimore

14

Informant
(Address)M. L. Ruppert
132 Collins Ave

15

Filed

MAY 24 1920

ROBERT E. ERAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 20, 1920, to May 23, 1920,

that I last saw him alive on May 22, 1920,

and that death occurred, on the date stated above, at 4:45 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(duration) yrs. mos. 3 da.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. A. O'Neill M. D.

, 19 (Address)

108 N. Baltimore Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cem.

May 24 1920

20 UNDERTAKER

Chas. W. Dill

ADDRESS

3109
Fredk. Ave.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43412

CERTIFICATE OF DEATH.

79 D43412

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2208 Presstman*ST.: *15*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Susan L. Dayton(a) RESIDENCE. No. *2208 Presstman*

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

50 yrs.

— mos.

— ds.

How long in U. S., if of foreign birth?

— yrs.

— mos.

— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*James Dayton*

6 DATE OF BIRTH (month, day, and year)

Jan 15th 1861

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*59**4**6*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Cambridge - ma*

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Cambridge - ma

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Cambridge - ma

14

Informant

(Address)

M. Kellert
2208 Presstman St

15

MAY 24 1920

ROBERT A. ERAUTER

Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 21st 1920*

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1 - 1920 to *May 21, 1920*that I last saw her alive on *May 21, 1920*and that death occurred, on the date stated above, at *8 P.* m.

The CAUSE OF DEATH* was as follows:

*Chronic Myocarditis
mitral Regurgitation*

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Acute Cardiac Dilatation*

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

E. B. Tremain

M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Weston Cemetery *May 24, 1920*

20 UNDERTAKER

ADDRESS

F. B. Kippert 2236 Fred St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

D43413

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43413

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.: *14* WARD)

2-FULL NAME

Charles E. Norris

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

#1401 McCulloh St.

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

50

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

widower

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*none*

6 DATE OF BIRTH (month, day, and year)

Feb 13 / 1883

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*67**2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Librarian 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Waterfield Md*

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Don't know

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Don't know

14

Informant

(Address)

*Stanley Norris
1401 McCulloh St.*

15

MAY 24 1920

ROBERT E. KRATZER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 22 1920

17

I HEREBY CERTIFY, That I attended deceased from

*May 3, 1920, to May 22, 1920,*that I last saw him alive on *May 22, 1920,*and that death occurred, on the date stated above, at *8:30 a.m.*

The CAUSE OF DEATH* was as follows:

Hypertrophied Prostate

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)*Pyemia*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Yes

Date of

May 6-1920

Was there an autopsy?

Yes

What test confirmed diagnosis?

(Signed)

W. G. Hayes

M. D.

, 19 (Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Mary's Cemetery**May 25 1920*

20 UNDERTAKER

ADDRESS

Woolcock 5028 North

TIONS is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Hks.
Exact statement of OCCUR-
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43414

CERTIFICATE OF DEATH.

40 ✓ D43414

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 St. Peter ST.: 11 WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura St. Barker

(a) RESIDENCE. NO. 820 St. Peter ST., _____ WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. _____ ds. _____
How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John P. Barker

6 DATE OF BIRTH (month, day, and year) Dec 16 1872

7 AGE Years 47 Months 0 Days 7 If LESS than 1 day, hrs. _____ or min. _____

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Abel Leadwader

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phil

12 MAIDEN NAME OF MOTHER May Ann Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Louis J. Barker
(Address) 820 St. Peter St.

15 MAY 24 1920 ROBERT B. LEATHER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to May 23, 1920, that I last saw him alive on May 22, 1920 and that death occurred, on the date stated above, at 5:50 m.
The CAUSE OF DEATH* was as follows:
Carcinoma Gall bladder

(duration) _____ yrs. 6 mos. _____ ds.

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis Clinical
(Signed) M. C. Friessner M. D.
Address 682 Col. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem DATE OF BURIAL May 26 1920

20 UNDERTAKER Wm Cork ADDRESS 7 + 5th

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43415

CERTIFICATE OF DEATH.

D43415

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

WARD.

(If nonresident, give city or town and State)

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

PARENTS

14 Informant
(Address)

15

MAY 24 1920

ROBERT H. KANTER

Basil Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from
May 17 1920, to May 21 1920
that I last saw him alive on May 21 1920
and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Snider, M. D.

522/20682 Col. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43416

D43416

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 North ChesterST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

SOPHIA R. SIEWIERSKI,

(a) RESIDENCE. NO.

Back River

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 10 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Frank Siewierski,

6 DATE OF BIRTH (month, day, and year) June 30-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At-Home. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore,

Md.,

10 NAME OF FATHER Gottlieb Weber,

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany,

12 MAIDEN NAME OF MOTHER Mary Maiger,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany,

PARENTS

14 Informant Rosa Fuchs, (Sister)
(Address) # 10 N. Chester Street.

15

MAY 24 1920

ROBERT R. ELADTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 20, 1920, to May 22, 1920.that I last saw him alive on May 22, 1920.and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease(duration) 7 yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. J. Mac, M. D., 19 (Address) Rowville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery.May 28 1920

20 UNDERTAKER

M. F. Sudowski.

ADDRESS

405 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43417

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43417

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3405 C. Fairmount ave. ST.: 26 WARD)

2-FULL NAME

Marie L. Russo

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 3405 C. Fairmount ave. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4 / 1899

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 21 4 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Texter hand in can shop

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

Vincent J. Russo

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Naples

12 MAIDEN NAME OF MOTHER

Ella Fallon

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Howard county Md

14

Informant (Address)

Mr. Bernard Russo 3405 C. Fairmount ave.

MAY 24 1920

ROBERT A. TRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1920

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1920, to May 22, 1920, that I last saw him alive on May 21, 1920, and that death occurred, on the date stated above, at 8 a. m. The CAUSE OF DEATH* was as follows:

acute Bright's disease (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinalysis

(Signed) A. C. O'Carroll M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer Cem. May 25 1920

20 UNDERTAKER

Jos. J. Herr 156 N. Luzerne ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43418

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *7th* WARD)2-FULL NAME *James Robert Williams*(a) RESIDENCE. NO. *Daughters of the Eucharist Catonsville* ST. *Life* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb. 1st 1920*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*3.**21*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *md.*10 NAME OF FATHER *James Aubrey Williams*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country)12 MAIDEN NAME OF MOTHER *Edith Greene*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *md.*

14

Informant (Address)

*Edith Williams**ROBERT I. FLAUGHTER*

15

File

*MAY 24 1920**Burial Permit*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 22 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*May 6 - 1920, to May 22, 1920.*that I last saw him alive on *May 22 - 1920.*and that death occurred, on the date stated above, at *7:30 a.m.*

The CAUSE OF DEATH* was as follows:

Prematurity

CONTRIBUTORY (Secondary)

(duration)

Birth

yrs.

mos.

ds.

(duration)

Birth

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death? *His home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Chloral*(Signed) *W. S. Hays* M. D., 19 (Address) *1111*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Landon Park**May 24 1920*

20 UNDERTAKER

ADDRESS

*W. S. Hays**1111*

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43419

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43419

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Wed. General Hosp.

ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Jacob Schultzy

(a) RESIDENCE. NO.

4334 Carey

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

53 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

53 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Pearl Schultzy

6 DATE OF BIRTH (month, day, and year)

Jan 21 - 1860

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

60

4

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer)

Contractor

(c) Name of employer

Self

9 BIRTHPLACE (city or town) (State or country)

Switzerland

10 NAME OF FATHER

Jacob Schultzy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Switzerland

12 MAIDEN NAME OF MOTHER

Wilmar

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Prussia

14

Informant (Address)

Pearl Schultzy 4334 Carey St

15

Filed

MAY 24 1920

ROBERT E. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 22 1920

17

I HEREBY CERTIFY, That I attended deceased from May 19, 1920, to May 22, 1920,

that I last saw him alive on May 22, 1920,

and that death occurred, on the date stated above, at 7:25 A.M.

The CAUSE OF DEATH* was as follows:

Septicemia (organism not known)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Cellulitis of arm & forearm

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

Yes Date of May 1920

Was there an autopsy?

Yes

What test confirmed diagnosis?

Chinese findings

(Signed)

William S. Dacey

M. D.

5/22/20 (Address)

Maryland General Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, or other disposal

Friendship Cemetery

DATE OF BURIAL

May 24 1920

20 UNDERTAKER

W. J. Dickerson & Sons

D43420

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

D43420

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 W. Tamar St. 16

ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Dora Balser

(a) RESIDENCE. No. 1724 W. Tamar St.

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

MAY 24 1920

ROBERT E. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 22, 1920, to May 22, 1920,

that I last saw him alive on May 22, 1920,

and that death occurred, on the date stated above, at 2 PM.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Hebrew Bur

May 24 1920

20 UNDERTAKER

ADDRESS 1121

Levinson

E. Balto 94

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assoc.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably such*, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Ate six pickles &
2 oranges night
before death.
Intestinal indigestion
No ptomaine poisoning*

D43422

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79
D43422
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3321 Belair Ave. ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 3321 Belair Ave. St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, May 31, 1880 (Month) (Day) (Year)

7-AGE, 69 yrs. 11 mos. 21 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Frederick Md. Maryland

10-NAME OF FATHER, John Stubbs

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Alma Kline

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Cook

(Address) 3321 Belair Ave.

15- MAY 24 1920 ROBERT E. RAUTER

Filed..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 21, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to May 21, 1920, that I saw her alive on May 20, 1920, and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) -clitis Asthma & Chronic Bronchitis

(Signed) A. L. Williamson M. D. 5/22, 1920. (Address) Roopburg.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Holy Redeemer Cemetery May 25, 1920

20-UNDERTAKER, ADDRESS, Frank L. Loefer, Fullerton Md.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43423

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2312 E Hoffman ST.; 8 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 2342 E Hoffman St.; life yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

M

4-COLOR OR RACE.

W.

5-SINGLE,

MARRIED,WIDOWED,OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Jan. 18, 1869
(Month) (Day) (Year)

7-AGE,

51 yrs., 4 mos., 4 ds.

IF LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

Veterian9-BIRTHPLACE,
(State or Country),Balto

10-NAME OF FATHER,

Thomas H Mears11-BIRTHPLACE OF FATHER
(State or Country),Va

12-MAIDEN NAME OF MOTHER

Martha Robinson13-BIRTHPLACE OF MOTHER
(State or Country),Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie B. Mears(Address) 2312 E. Hoffman

15-

MAY 24 1920

ROBERT B. KRAUTER

Baltimore, Md. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 22, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 25 1920, to May 22 1920,that I saw him alive on May 22 1920,and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Neuronic Cerebral(Duration) yrs., mos., 1 ds.CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis(Duration) 2 yrs., mos., ds.(Signed) J. Frederick S. Mears M. D.May 23, 1920 (Address) 1301 N. Pat Bk

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Balto Cemetery

DATE OF BURIAL,

May 25, 1920

20-UNDERTAKER,

Robt J. Turner

ADDRESS

1442 N Broadway

D43424

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43424

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

New City Hospital ST. 26

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Wm Laurence

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

Length of residence in city or town where death occurred

50

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

50

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1840

7 AGE

80

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

815

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Unknown

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Hospital Records New City Hosp.

15

MAY 24 1920

ROBERT E. LAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6-23 1920

17

I HEREBY CERTIFY, That I attended deceased from

10-14 1914, to 6-23 1920

that I last saw him alive on 6-22 1920

and that death occurred, on the date stated above, at 9:30 A. M.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic diffuse Nephritis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

No special test

(Signed)

J. P. Perrell

M. D.

6-23, 1920 (Address)

Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery

May 24 1920

20 UNDERTAKER

ADDRESS

Harry H. Witzke

1531 Highland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instructions on back of certificates.

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very important.

D43425 HEALTH DEPARTMENT—CITY OF BALTIMORE D43425
CERTIFICATE OF DEATH. X 159
PLACE OF DEATH
CITY OF BALTIMORE (No. 32 E. Weber St. ST.: 23 WARD)
2-FULL NAME Stefano Mannina.
(Residence in Baltimore: No. 32 E. Weber St. St.: yrs. --- mos. 0 ds.)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.
3-SEX, Male. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single. (Write the word.)
6-DATE OF BIRTH, Do not know, / (Month) (Day) (Year)
7-AGE, 47 yrs. --- mos. --- ds. If LESS than 1 day, ...hrs. or ...min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Laborer. 04
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country), Italy.
PARENTS.
10-NAME OF FATHER, Joseph Mannina.
11-BIRTHPLACE OF FATHER (State or Country), Italy.
12-MAIDEN NAME OF MOTHER, Antonia Jones.
13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Abramo Mannina (brother) 206 E. Milwaukee St. (Address) Detroit, Mich.
15- MAY 24 1920 BOBBERY R. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.
16-DATE OF DEATH, May 20th. 1920, 191 (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Pistol shot wound in the head.
Suicide.
(Duration) yrs. --- mos. --- ds.
CONTRIBUTORY (Secondary) (Duration) yrs. --- mos. --- ds.
(Signed) Otto M. Reinhardt M. D. (Coroner.)
May 23rd 1920 (Address) 1017 S. Charles St.
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place In the of death yrs. --- mos. --- ds. State yrs. --- mos. --- ds.
Where was disease contracted, if not at place of death?
Former or usual residence Detroit Mich.
19-PLACE OF BURIAL OR REMOVAL, Detroit Mich. DATE OF BURIAL, May 24 1920
20-UNDERTAKER, John F. Denny ADDRESS, 715 Light St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43426

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1141 Riverside Ave.)

ST.;

WARD)

2-FULL NAME

Emma Marie Roth

(Residence in Baltimore: No. 1141 Remonden St.)

yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Ches

6-DATE OF BIRTH,

May 22, 1920
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day,

yrs. mos. ds.

5 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Ches. god

9-BIRTHPLACE,
(State or Country),

Mdts

10-NAME OF FATHER,

Chas F Roth

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Clara Ruth

13-BIRTHPLACE OF MOTHER
(State or Country),

Mdts

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Charles F. Roth

(Address)...

1141 Riverside Ave

15-

MAY 24 1920

ROBERT E. KRAUTER

Filed

191

BUTEL PRINTING CO.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 22, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

May 22, 1920, to May 22, 1920,

that I saw him alive on May 22, 1920,

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Primitia
7 months gestation
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Kottner M. D.

191... (Address)...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Cedar Hill Cem

May 24, 1920

20-UNDERTAKER

Miss E. E. Evans

ADDRESS

1428 Maple St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43427

CERTIFICATE OF DEATH.

D43427

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

MAY 24 1920

ROBERT B. KRAUTER

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

find that said deceased came to death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed) M. D.

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43428

D43428

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leah Furhman(a) RESIDENCE. NO. 622 N. Eutam St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

18 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1881

7 AGE

Years

Months

Days

39

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) England
(State or country)

10 NAME OF FATHER

Louis Rosenstein11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)

14

Informant Hospital Records
(Address) New City Hospital

15

MAY 24 1920ROBERT F. LAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 22, 19 20

17

I HEREBY CERTIFY, That I attended deceased from

February 28 19 20, to May 22, 19 20.that I last saw her alive on May 21, 19 20.and that death occurred, on the date stated above, at 5:22 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus.

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Frank T. Barker, M. D.22. 1920 Address New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hehren Herron Run5/24 19 20

20 UNDERTAKER

ADDRESS

Jack Lewis1411 5th Ave

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43429

CERTIFICATE OF DEATH.

D43429

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *New City Hospital* ST. *26* WARD)

2-FULL NAME

Esther Samrodin

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>F</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Widowed</i>
5a If married, widowed, or divorced HUSBAND of (or) WIFE of		
6 DATE OF BIRTH (month, day, and year) <i>1888</i>		
7 AGE <i>32</i>	Years	Months Days
If LESS than 1 day, hrs. or min.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Tailorress 880*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Russia*
(State or country)10 NAME OF FATHER *Alex. Smotrutsky*11 BIRTHPLACE OF FATHER (city or town) *Russia*
(State or country)12 MAIDEN NAME OF MOTHER *Famine Vitis*13 BIRTHPLACE OF MOTHER (city or town) *Russia*
(State or country)14 Informant *New City Hospital*
(Address) *Balt. Md.*15 *MAY 24 1920* *ROBERT A. FRAUTER*
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-23 1920*

17 I HEREBY CERTIFY, That I attended deceased from *4-21*, 19*20* to *5-23*, 19*20*, that I last saw her alive on *5-23*, 19*20*, and that death occurred, on the date stated above, at *1:05 P.M.*

The CAUSE OF DEATH* was as follows:

Carcinoma of ovary(duration) yrs. *10* mos. ds.CONTRIBUTORY *Metastasis to peritoneum*
(Secondary) *glands* (duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *No special test*(Signed) *J. H. Jones*, M. D.*5-23, 1920* (Address) *Bay View Hotel*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Bellevue Int. Cemetery**May 24 1920*

20 UNDERTAKER

ADDRESS

*Jack Lewis**1411 E. 11th*

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43430

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 RidgelyST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pearl Templeton(Residence in Baltimore: No. 1531 Ridgely StSt.; 5 yrs., - mos., - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female4-COLOR OR RACE, White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH, Apr 4, 1889

(Month)

(Day)

(Year)

7-AGE, 31 yrs., 1 mos., 17 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Wash. D.C.

PARENTS.

10-NAME OF FATHER, Wm H Bate11-BIRTHPLACE OF FATHER (State or Country) Wash. D.C.12-MAIDEN NAME OF MOTHER May C Shea13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. E. H. Hammer(Address) 8118 Magnolia St

15-MAY 24 1920

Filed....., 191.....

ROBERT H. KRAUTER

BUTAL FETTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH May 22, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20, 1920, to May 22, 1920, that I saw her alive on May 21 - 1920, and that death occurred, on the date stated above, at 9⁰⁰ a.m.

The CAUSE OF DEATH* was as follows:

Heart failure
(Duration).....yrs.....mos.....ds.CONTRIBUTORY (Secondary) Emphysema(Signed) E. H. Hammer M. D.
5727, 191... (Address) 1302 N. Bond St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Trinity CemDATE OF BURIAL, May 24, 192020-UNDERTAKER, Philp HerwigADDRESS 2016 Orleans

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43431

CERTIFICATE OF DEATH.

170 D43431

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 W. Haffman ST. 17 WARD)

2-FULL NAME John R. Pratt

(a) RESIDENCE. No. 513 W. Haffman ST. 17th WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7008-1840

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

MAY 24 1920

ROBERT B. KRAUTER Registrar

Burial Permit 01222

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1920

17

I HEREBY CERTIFY, That I attended deceased from

Nov 1, 1919, to May 22, 1920,

that I last saw him alive on May 20, 1920,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

CONTRIBUTORY

(Secondary)

Chronic Bronchitis (duration) 6 yrs. mos. ds.

Hepatitis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? uricary A. E. S.

(Signed) Bernard J. G. M. D.

707 Hammond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel Cemetery

May 25 1920

20 UNDERTAKER

ADDRESS 1234

John M. Johnson

Elting St.

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43432

CERTIFICATE OF DEATH.

29 D43432

1-PLACE OF DEATH

M.S. Marine Hospital 10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: WARD)

2-FULL NAME

Leo P. Kelly

(a) RESIDENCE. NO.

411 E. Biddle St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Hrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec. 28/1891

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

28

4

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

General

(c) Name of employer

9 BIRTHPLACE (city or town).
(State or country)Balt.
Maryland

10 NAME OF FATHER

James P. Kelly

11 BIRTHPLACE OF FATHER (city or town).
(State or country)Balt.
Md.

12 MAIDEN NAME OF MOTHER

Nellie Brannan

13 BIRTHPLACE OF MOTHER (city or town).
(State or country)Balt.
Md.

14

Informant
(Address)Mr. James P. Kelly
411 E. Biddle St.

15

Filed

MAY 24 1920

ROBERT E. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5/22 1920

17

I HEREBY CERTIFY, That I attended deceased from

4/23 1920 to 5/22 1920

that I last saw him alive on 5/22 1920

and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute pulm. miliary
tuberculosis

(duration) yrs. 1 mos. 22 ds.

CONTRIBUTORY
(Secondary)

Secondary anemia

(duration) yrs. 1 mos. 22 ds.

18 Where was disease contracted

if not at place of death?

Baltimore City

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Chas. H. Magel M. D.

, 19 (Address) U.S. Marine Hosp. Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery

May 25 1920

20 UNDERTAKER

ADDRESS

Missy Horvath

134 E. Egan St.

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43433

CERTIFICATE OF DEATH.

b4 D43433

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 E Eager

ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 930 E Eager

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

60 yrs.

11 mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Husband of John J. Leonard

6 DATE OF BIRTH (month, day, and year)

June 23rd 1859

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

60

11

—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Mund. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt. Md

10 NAME OF FATHER

James Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Margaret Leonard

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Mr. John J. Leonard 930 E Eager

15

File

MAY 24 1920

ROBERT E. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 23rd 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 1, 1920, to May 23, 1920,

that I last saw ~~her~~ alive on May 22, 1920,and that death occurred, on the date stated above, at 2³⁰ ⁰⁰ m.

The CAUSE OF DEATH* was as follows:

Atherosclerosis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

930 E Eager

Did an operation precede death? ☒ Date ofWas there an autopsy? ☒

What test confirmed diagnosis?

Clinical

(Signed)

James M. Hays M. D.

6/23/20

Address 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL

New Catholic Cemetery

DATE OF BURIAL

May 26 1920

20 UNDERTAKER

Henry Horst, Son

ADDRESS

1301 E Eager

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43434

CERTIFICATE OF DEATH.

28 D43434

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 N. Central Ave. ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William H. Powers

(a) RESIDENCE

No. 1222 N. Central Ave. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 11 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Margaret S. Powers

6 DATE OF BIRTH (month, day, and year)

June 11, 1883

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

36

11

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Motor man for 078

(b) General nature of industry,
business, or establishment in
which employed (or employer)

United Railway Co.

(c) Name of employer

Sayre & Co. Inc.

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md.

10 NAME OF FATHER

Joseph F. Powers

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

New Jersey

12 MAIDEN NAME OF MOTHER

Elizabeth Young

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Baltimore Md.

14

Informant
(Address)Mrs Margaret S. Powers
1222 N. Central Ave.

15

Filed

MAY 24 1920

ROBERT B. KRAUTER
Barial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 23, 1920

17

I HEREBY CERTIFY, That I attended deceased from
about Apr. 14, 1920, to May 23, 1920.

that I last saw him alive on May 23, 1920.

and that death occurred, on the date stated above, at 4:45 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Died

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Died from
History of influenza

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. S. Riley, M. D.

, 19 (Address)

1039 King

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore County

May 26, 1920

20 UNDERTAKER

ADDRESS

Henry Horok Inc

1301 E. Bay St

This is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43435
1-PLACE OF DEATHCITY OF BALTIMORE: (No. 1916 Lennon ST. 20 WARD)2-FULL NAME Minnie S. Wolff(Residence in Baltimore: No. 1916 Lennon St. St.; 26 yrs., 1 mos., 4 ds.)28 D43435
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single6-DATE OF BIRTH, April 17, 1894
(Month) (Day) (Year)7-AGE, 26 yrs., 1 mos., 4 ds. If LESS than 1 day,hrs. or....min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Operator 086
(b) General nature of industry, business, or establishment in which employed (or employer). Button Factory9-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, Frederick J. Wolff11-BIRTHPLACE OF FATHER (State or Country), Baltimore12-MAIDEN NAME OF MOTHER Annie Carl13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frederick S. Wolff(Address) 1916 Lennon St.15- MAY 24 1920 ROBERT E. KRAUTERFiled 191 Baltimore Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 21, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to May 21, 1920, that I saw her alive on May 20, 1920, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) 3 yrs., 0 mos., 0 ds.CONTRIBUTORY (Secondary) None(Duration) 0 yrs., 0 mos., 0 ds.(Signed) M. J. O'Neill M. D.
May 23, 1920 (Address) 108 N. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park DATE OF BURIAL, May 25, 192020-UNDERTAKER Geo. H. Schwal ADDRESS 2101 E. Pratt

See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT - CITY OF BALTIMORE

D43436

CERTIFICATE OF DEATH

REGISTERED NO. C

D43436

PLACE OF DEATH

CITY OF BALTIMORE (No. 2024 E Fayette

ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME James W. Harpel

(Residence in Baltimore: No. 2024 E Fayette

St. 31 yrs. 8 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6-DATE OF BIRTH Sept 5, 1884 (Month) (Day) (Year)

7-AGE 35 yrs. 8 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Hardwood Finisher & Decorator

9-BIRTHPLACE (State or country) Balto Maryland

10-NAME OF FATHER Otto A Harpel

11-BIRTHPLACE OF FATHER (State or country) Maryland

12-MAIDEN NAME OF MOTHER Emma Schilling

13-BIRTHPLACE OF MOTHER (State or country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Ann B. Harpel

(Address) 2024 E Fayette

15 MAY 24 1920

Filed 1920

ROBERT C. KAUFER

Barial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 22, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to May 22, 1920,

that I saw him alive on May 20, 1920,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. 2 mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Eugene S. Persagno M. D. May 24, 1920 (Address) 2314 E. Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Holy Redeemer Ch 6/25, 1920

20-UNDERTAKER ADDRESS

George A. Tuller 2024 E Fayette

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state
TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec. 6-9-19 H. P. Co. 1000 Hks.

This is the correct certificate

D43437

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43437

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *615 Bider Alley* ST.: *WARD*)

2-FULL NAME

Naomi Mafume

(a) RESIDENCE. No. *615 Bider Alley* ST.: *WARD*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *8*

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F.*

4 COLOR OR RACE *C.*

5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept 11, 1919*

7 AGE

Years

Months *8*

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Ind.*
(State or country)

10 NAME OF FATHER *William Mafume*

11 BIRTHPLACE OF FATHER (city or town) *Ind.*
(State or country)

12 MAIDEN NAME OF MOTHER *Maggie Kent*

13 BIRTHPLACE OF MOTHER (city or town) *Ind.*
(State or country)

14

Informant
(Address)

15

Filed

May 6 1920

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 23 1920*

17

I HEREBY CERTIFY, That I attended deceased from *May 21*, 19*20*, to *May 23*, 19*20*, that I last saw him alive on *May 22*, 19*20*, and that death occurred, on the date stated above, at *4:30 PM*. The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Henry H. Weinberger*, M. D.

Nov. 19 (Address) *724 W. Fayette St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

013437

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 Cedar Alley ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 615 Cedar Alley St.; 4 yrs., 12 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6-DATE OF BIRTH,

Sept. 16, 1919
(Month) (Day) (Year)

7-AGE,

8 yrs., 1 mos., 12 ds.

If LESS than 1 day,

8 hrs. or 12 min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Baltimore Md

10-NAME OF FATHER,

William Bethune

11-BIRTHPLACE OF FATHER, (State or Country),

South Carolina

12-MAIDEN NAME OF MOTHER

Maggie Johnson

13-BIRTHPLACE OF MOTHER, (State or Country),

South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Maggie Johnson

(Address) 615 Cedar Alley

15-MAY 24 1920

ROBERT B. TRAUTER

101...Baptist...01041...Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 21, 1920, to May 23, 1920,

that I saw her alive on May 22, 1920,

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchitis pneumonia

(Duration) 2 yrs., 1 mos., 12 ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs., 1 mos., 12 ds.

(Signed) D. L. Johnston M. D.

May 24, 1920 (Address) 223 W. Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs., 1 mos., 12 ds. In the State 1 yrs., 1 mos., 12 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn

DATE OF BURIAL,

May 24, 1920

20-UNDERTAKER

L. H. Brown

ADDRESS

101 W. Mont 981

HAMPSON JONES, M. D.
COMMISSIONER
FREDERICK HEMPEL, M. D.
ASSISTANT COMMISSIONER
E. HOGAN, M. D.
ASSISTANT COMMISSIONER
ED GAITHER,
- SECRETARY



HEALTH DEPARTMENT NOV 6 1920

NOV 6 1920

To whom it may concern

In reference to the attached
certificate I would stated in order to get a
correct record of same. We found it necessary
have our Health Officer Dr Weinberger investigate
his case and furnish this department with the
true facts as near as possible.

Yours respectfully
Geo H Greer
Indel Clerk.

NOV 6 1920

8 43437
HAMPSON JONES, M. D.
COMMISSIONER
FREDERICK HEMPEL, M. D.
ASSISTANT COMMISSIONER
F. HOGAN, M. D.
ASSISTANT COMMISSIONER
EED GAITHER,
SECRETARY



HEALTH DEPARTMENT

October 31, 1920

Dr. J. F. Hempel,
Asst. Commissioner of Health.

Dear Doctor:

Relative to the death of the infant "Lillian Johnson" of 615 Cider Alley, I beg to state the following facts.

It seems that one Maggie Kent had two children, one being born on April 2, 1917 and named Lillian Johnson (father's name being Charles Johnson) and the other born in ^{May} ~~April~~ 1919 and named ^{Maouie} ~~Cornelia~~ Mafume (father's name being William Mafume). It was the latter child that died and the mother inadvertently gave the undertaker the name of the living child.

As per your instruction, I will file both birth certificates and would advise that the death certificate be changed accordingly. The address of Maggie Kent is 813 Hanover Street.

Very truly yours,

Henry H. Weinberger MD

NOV 6 1920

Health Officer, 4th District.

D-43437

Baltimore, Md., November, 3, 1920.

I do hereby make oath that the name of the deceased given on Baltimore City Health Department Death Certificate No. D-43437 as Lillian Johnson is not correct. This name was given by Dr. J. L. Shelton, 203 W. Hamburg Street, who made out the Death Certificate, but he was misinformed concerning said facts.

My first child, Lillian Johnson, by my husband Charlie Johnson, to whom I was legally married, is still living.

My second child, Naomi Mafume, by my common law husband, William Mafume, is the one who died on May 23, 1920, at 615 Cider Alley, and whose name should be recorded on said Death Certificate.

I am now living with William Mafume and have resumed my maiden name of Maggie Kent.

Maggie Kent.

Mother.

Subscribed and sworn to before me this 3d day of November,
20.

Reed Gaither.

Notary Public.

NOV 6 1920

N. B.—Every item of information should be carefully supplied. Accuracy is very important. See instructions on back of certificate.

D43438

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Balto Gen Hospital* ST. *8* WARD)

2-FULL NAME

(Residence in Baltimore: No. *16234 Patterson Park Ave.* St. *27* yrs., *1* mos., *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

May *8*, 18*64*
(Month) (Day) (Year)

7-AGE,

56 yrs. *14* mos. *14* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

Carpenter
oil

9-BIRTHPLACE, (State or Country),

Carroll Co. Md.

10-NAME OF FATHER,

Cornelius Jenkins

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Mary Farver

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Ella Jenkins*

(Address) *1623 Patterson Park Ave*

15-

MAY 24 1920

ROBERT E. KRAUTER

REGISTERED

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

5 *22*, 19*20*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *5-5* 19*20*, to *5-22* 19*20*,

that I saw him alive on *19*, and that death occurred, on the date stated above, at *9:52* AM.

The CAUSE OF DEATH* was as follows:

Sub-diaphragmatic Abscess following Acute appendicitis.

(Duration).....yrs.....mos.....*21*.....ds.

CONTRIBUTORY (Secondary) *Septicemia*

(Duration).....yrs.....mos.....*4*.....ds.

(Signed) *R. R. Reynolds* M. D.

5-22, 19*20* (Address) *1213 Light St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....*17*.....ds. In the State *56* yrs. *14* mos. *14* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *1623 N. Patterson Park Ave*

19-PLACE OF BURIAL OR REMOVAL,

Berrett Carroll Co. Md

DATE OF BURIAL,

May 24, 1920

20-UNDERTAKER

Geo. A. Gerbig 2001 W. Baltimore St

ADDRESS

CASE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D43439

HEALTH DEPARTMENT—CITY OF BALTIMORE,

CERTIFICATE OF DEATH.

115

D43439

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mrs. Hoef*

ST.: *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *2436 E. Monument*

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Noether

6 DATE OF BIRTH (month, day, and year)

3/7/1878

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42

2

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Henry R. Kline

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Penna.

12 MAIDEN NAME OF MOTHER

Mary Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md.

14

Informant (Address)

John Noether 2436 E. Monument St.

15

Filed

MAY 24 1920

ROBERT A. LAUTER

Registrar

Basal Permit Closed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/22 1920*

17

I HEREBY CERTIFY, That I attended deceased from *5/8* 19*20*, to *5/22* 19*20*, that I last saw him alive on *5/22* 19*20*, and that death occurred, on the date stated above, at *7:35* a.m. The CAUSE OF DEATH* was as follows:

Acute Gangrenous Cholecystitis

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. *Acute Chronic Cholecystitis*

15 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *5/6/20*

Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Wm. C. Ridgely* M. D.

5/22/20 (Address) *Mrs. Hoef*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Gen.

DATE OF BURIAL

May 25 1920

20 UNDERTAKER

H. Sander Sons

ADDRESS

1200 Pk. St.

D43440

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

H7 D43440

PLACE OF DEATH

CITY OF BALTIMORE (No. 1143 Ward

ST. 21 WARD)

FULL NAME

Effie M. McKeldin

(Residence in Baltimore: No. 1143 Ward St

St.: yrs. 4 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Widow

6-DATE OF BIRTH,

May 1, 1873
(Month) (Day) (Year)

7-AGE,

47 yrs. 21 ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

at home

9-BIRTHPLACE, (State or Country),

Baltimore City

10-NAME OF FATHER,

Geo W Beach

11-BIRTHPLACE OF FATHER

(State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Mary Hamilton

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm A Carson

(Address)

1143 Ward St

15-

Filed

MAY 24 1920

ROBERT E. LAUTER

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 22, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, au-

topsy or inquiry, find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Erythraemia
Rheumatic

(Duration) 1 yrs. 21 mos. ds.

CONTRIBUTORY (Secondary)

Acute dilatation of heart

(Signed) James M. Keen

(Duration) 2 yrs. 21 mos. ds.

MAY 23, 1920 (Address) 2001 Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Mount Carmel

DATE OF BURIAL,

May 25, 1920

20-UNDERTAKER

H. Sander Sam

ADDRESS

1710 Fleet St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43441

CERTIFICATE OF DEATH.

91

D43441

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Johnson(a) RESIDENCE. No. 1719 Presbury St.

ST., _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

Black

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

54

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Housework

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)10 NAME OF FATHER Simon Gaskin11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)12 MAIDEN NAME OF MOTHER Jane Kral May 22, 192013 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14

Informant Hospital Records(Address) New City Hospital.

15

MAY 24 1920 ROBERT E. LAUFER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21, 1920

17

I HEREBY CERTIFY, That I attended deceased from
March 23, 1920, to May 21, 1920
that I last saw him alive on May 21, 1920
and that death occurred, on the date stated above, at 4:30 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Arthritis(duration) yrs. 6 mos. ds.CONTRIBUTORY Broncho-Pneumonia
(Secondary)(duration) yrs. mos. 7 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No special test(Signed) J. P. Russell M. D.Address) New City Hospital.*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

At Cemetery MAY 24 1920

20 UNDERTAKER

JAMES H. DENNIS

ADDRESS

1303 FRESTMAN ST.

PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43442

HEALTH DEPARTMENT-CITY OF BALTIMORE

D43442

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 45 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6-DATE OF BIRTH October 8, 1854 (Month) (Day) (Year)

7-AGE 65 yrs. 7 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Retiree (b) General nature of industry, business, or establishment in which employed (or employer) Wholesale Grocery Salesman 066

9-BIRTHPLACE (State or country) Manchester Carroll Co. Md.

10-NAME OF FATHER Henry Steffy

11-BIRTHPLACE OF FATHER (State or country) Pennsylvania

12-MAIDEN NAME OF MOTHER Miss Williams

13-BIRTHPLACE OF MOTHER (State or country) Carroll Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Steffy

(Address) Chapel Gate Lane

15. MAY 24 1920 ROBERT E. LAUTER

BURIAL PERMIT REQUIRED

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 12, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1919, to May 22, 1920, that I saw him alive on May 22, 1920, and that death occurred, on the date stated above, at 9 P. M. The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(Duration) 6 yrs. mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Marshall B. Wirt M. D. May 23, 1920 (Address) Catonsville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Louisa Park Co. May 21, 1920

20-UNDERTAKER ADDRESS Joseph B. Cook 1603 N. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43443

D43443

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2028 Mt Royal Ave ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Jowles(Residence in Baltimore: No. 2028 Mt Royal Ave St.; 59 yrs., 9 mos., 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

white5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the words)single

6-DATE OF BIRTH,

July 25, 1860
(Month) (Day) (Year)

7-AGE,

59 yrs., 9 mos., 27 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Mfg. - Lumber
0459-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant):

(Address):

15-

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 22, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from October 13 1919, to May 22 1910, that I saw him alive on May 20 1910, and that death occurred, on the date stated above, at 8:59 a.m.
The CAUSE OF DEATH* was as follows:ArteriosclerosisSymptoms
(Duration).....yrs. 7 mos.ds.CONTRIBUTORY
(Secondary)(Duration).....yrs. 6 mos.ds.(Signed) Louis P. Hamburger M. D.May 24, 1920. (Address) 1207 Eastman St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Green Mount May 25, 1910

20-UNDERTAKER

ADDRESS

John O. Mitchell 1207 Eastman St.

Important. See instructions on back of certificate.

MAY 24 1920

Burial Permit Clerk.
191
Registrar, Bert P. Harrison

D43444

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43444

CERTIFICATE OF DEATH.

X 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 Rossiter Ave WARD)2-FULL NAME Dr Joseph Grady Emerson(a) RESIDENCE. NO. 529 Rossiter Ave WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 8 mos. 0 ds. How long in U. S., if of foreign birth? 4 yrs. 0 mos. 16 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Resident

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Roe Emerson6 DATE OF BIRTH (month, day, and year) May 7-18667 AGE Years 54 yrs Months ✓ Days 16 days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Dentist

(b) General nature of industry, business, or establishment in which employed (or employer)

Dentistry

(c) Name of employer

Self9 BIRTHPLACE (city or town) Meridian (State or country) Mississippi10 NAME OF FATHER William Burr Emerson11 BIRTHPLACE OF FATHER (city or town) Ashville (State or country) South Carolina12 MAIDEN NAME OF MOTHER Mary Grady13 BIRTHPLACE OF MOTHER (city or town) Meridian (State or country) Mississippi14 Informant Mrs J. R. Emerson (Address) 529 Rossiter Ave Wife15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23rd 192017 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1919, to May 23rd, 1920, that I last saw him alive on May 23rd, 1920, and that death occurred, on the date stated above, at 2:15 P. M. The CAUSE OF DEATH* was as follows:Chronic myocarditis(duration) 20 yrs. 0 mos. 0 ds.CONTRIBUTORY Cirrhosis of Liver (Secondary)(duration) 5 yrs. 0 mos. 0 ds.18 Where was disease contracted? ? if not at place of death?Did an operation precede death? no Date of -Was there an autopsy? noWhat test confirmed diagnosis none(Signed) Robert Shultell, M. D.19 PLACE OF BURIAL, CREMATION OR REMOVAL Graves to Md DATE OF BURIAL May 25 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 UNDERTAKER Stewart & Mowen Company ADDRESS 108 W. North AveStewart & Mowen Company

(WILLIAM F. WOODEN, Successor)

108 W. NORTH AVE

Physician should state exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 24 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43446

D43446

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Shuman(a) RESIDENCE. NO. 129 N. Curley St.ST. Unknown WARD.

(Usual place of abode)

Unknown

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)MaleWhiteSingle6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1875.

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.45

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workMachinist 031(b) General nature of industry,
business, or establishment in
which employed (or employer)Unknown

(c) Name of employer

Unknown9 BIRTHPLACE (city or town)
(State or country)Austria

10 NAME OF FATHER

Joseph ?11 BIRTHPLACE OF FATHER (city or town)
(State or country)Germany12 MAIDEN NAME OF MOTHER Eleanor Friberger13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Germany

14

Informant
(Address)Hospital Records
H.T.H.

15

Filed

Robert P. Harrison

Registrar

MAY 24 1920

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22, 1920

17

I HEREBY CERTIFY, That I attended deceased from
May 10th, 19 20, to May 22, 19 20.that I last saw him alive on May 21, 19 20.and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) yrs. 6 mos. ds.CONTRIBUTORY Constitutional inferiority
(Secondary) with deterioration 2 yrs. (?) mos. ds.

18 Where was disease contracted

if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis T.B. in sputum.(Signed) George R. Wilkerson M. D.
5-22-20. Municipal Tbc. Hospital.
19 (Address)*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLANDMAY 24 1920

20 UNDERTAKER

ADDRESS

James M. McCall

JAMES M. MCCALL

D43447

HEALTH DEPARTMENT - CITY OF BALTIMORE

D43447

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE (No. "11" "11" "11" ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds. How long in U. S. If of foreign birth?

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

16 DATE OF DEATH (month, day, and year)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

17

I HEREBY CERTIFY, That I attended deceased from May 22, 1920, to May 22, 1920, that I last saw him alive on May 22, 1920, and that death occurred, on the date stated above, at 3:15 a. m. The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration)

ys.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

ys.

mos.

ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

May 22, 1920 Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

TUTION is very important. See instructions on back of certificates.

MAY 24 1920

Report P. Harrison,

Registrar

Bureau Permit Clerk.

Bennett & Son.

5/25 1920

3617 Bluff

D43448

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43448

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1711 1/2 Franklin* ST.; *19* WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1711 1/2 Franklin* St.; *2* yrs., *9* mos., *9* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

*Wht.*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) *Single*

6-DATE OF BIRTH,

March 14, 1920
(Month) (Day) (Year)

7-AGE,

2 yrs., 9 mos., 9 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
*none*9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Ludwig C. G. G. G.*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*12-MAIDEN NAME OF MOTHER *Mrs. Regan*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George Frederickson*(Address) *217 S. Penn.*

15-

Robert P. Harrison,

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 23, 1920*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from *May 23, 1920*that I saw her alive on *May 22, 1920*and that death occurred, on the date stated above, at *9:00 A. M.*

The CAUSE OF DEATH* was as follows:

Cirrhosis(Duration)yrs.....mos....*4*....ds.CONTRIBUTORY (Secondary) *Colic*(Duration)yrs.....mos....*1*....ds.(Signed) *W. H. Harrison* M. D.514, 9th (Address) *1735 N. Hollis St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of deathyrs.....mos.....ds. In the Stateyrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Linden Park Cem.*DATE OF BURIAL, *May 25, 1920*20-UNDERTAKER *for Frederickson Son*ADDRESS *217 S. Penn.*

Important. See instructions on back of certificate.

MAY 24 1920

state
is very
important. See instructions on back of certificate.

043449

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

043449

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 1238 Riverside Ave.

St.

WARD)

FULL NAME

Vernon W. Sweet.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1238 Riverside Ave.

St. yrs.

10 mos.

3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male.

4-COLOR OR RACE,

White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single.

6-DATE OF BIRTH,

July 20th. 1918

(Month)

(Day)

(Year)

7-AGE,

1

yrs.

10

mos.

3

da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None.

9-BIRTHPLACE, (State or Country),

Baltimore Md.

PARENTS.

10-NAME OF FATHER,

Louis R. Sweet.

11-BIRTHPLACE OF FATHER

(State or Country),

Ellicott City Md.

12-MAIDEN NAME OF MOTHER

Tuxanna Fowler.

13-BIRTHPLACE OF MOTHER

(State or Country),

Solomons Island. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis R. Sweet. (father)

(Address) 1238 Riverside Ave.

15-

Robert P. Harrison,

Filed

191

Burial Permit

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 23rd. 1920.

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry.

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

inquiry and that said deceased came to his death

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Scalded about the neck and body by scalding water. Accidental death.

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) M. D.

May 24 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cedar Hill Cem

May 26 1920

20-UNDERTAKER

ADDRESS 1039

E. Schuman Son

D43451

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 134-145 Belvedere Ave. ST. 27 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 134-145 Belvedere ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds.

mos.

How long in U. S. If of foreign birth? 35 yrs. mos. ds.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

H. McCauley

6 DATE OF BIRTH (month, day, and year)

Oct 8-1885

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

34

7

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Harrisonburg Va

10 NAME OF FATHER

Virgil L Baughner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Mary B Landis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14 Informant (Address)

H. McCauley 134-145 Belvedere Ave

15 Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 23 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 19, 1920, to May 23, 1920,

that I last saw him alive on May 22, 1920,

and that death occurred, on the date stated above, at 12-m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of heart, Broken Compensation with distention, do not know (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? do not know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. C. Castello, M. D.

19 (Address) 335 E. 31st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cem

May 26 1920

20 UNDERTAKER

ADDRESS

H. J. Tuckman

1000 1/2

MAY 24 1920

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43452

D43452

CERTIFICATE OF DEATH.

6-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 236 S. Exeter ST. 3 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give the NAME (instead of street and number and fill out No. 18.)

#-FULL NAME

(Residence in Baltimore: No. 236 S. Exeter St.; 1 yrs., 10 mos., 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

July 4, 1918
(Month) (Day) (Year)

7-AGE,

1 yrs., 10 mos., 19 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Ettore Naddes

11-BIRTHPLACE OF FATHER
(State or Country),

Italy

12-MAIDEN NAME OF MOTHER

Maria Carozzi

13-BIRTHPLACE OF MOTHER
(State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ettore Naddes(Address) 236 S. Exeter St.

15-

Robert P. Harrison,

May 24 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20 1920, to May 23 1920, that I saw her alive on May 22 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ... yrs. ... mos. ... ds. 2

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds. 4

(Signed) Eugene P. Peasano M. D.

May 24, 1920 (Address) 2319 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemery Ch.

DATE OF BURIAL,

May 25, 1920

20-UNDERTAKER

George J. Ruth

ADDRESS

1735 - Harbor Ave

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very important.

D43453

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Madison
42 5-37
D43453

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 N. Calvert - ST.: 17 WARD)

2-FULL NAME

(a) RESIDENCE, NO. 1619 N. Calvert - ST.: 17 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

MAY 24 1920

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1919, to May 24, 1920, that I last saw h.e. alive on May 24, 1920, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of uterus

(duration) yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary)

Heart failure (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Scan of uterus

(Signed) Arthur W. G. M. D.

, 19 (Address) 231 E. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43454

HEALTH DEPARTMENT—CITY OF BALTIMORE

003
175-
D43454

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *N. P. J.*, ST.: *12* WARD) REGISTERED NO. C
2-FULL NAME *Luther M. Peyton* (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1S.)
(Residence in Baltimore: No. *411 N. 23rd*, St.: *16* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married* (Write the word.)
6-DATE OF BIRTH, *April 7, 1886* (Month) (Day) (Year)
7-AGE, *34* yrs., *1* mos., ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *machinist*
(b) General nature of industry, business, or establishment in which employed (or employer), *helper, (Rail Road)*

9-BIRTHPLACE, (State or Country), *Virginia*
PARENTS.
10-NAME OF FATHER, *Joseph E. B. Peyton*
11-BIRTHPLACE OF FATHER (State or Country), *Va*
12-MAIDEN NAME OF MOTHER, *Ruth E. Hoff*
13-BIRTHPLACE OF MOTHER (State or Country), *Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Helen M. Peyton*
(Address) *411 N. 23rd St.*

15- *Robert P. Harrison,*
MAY 24 1920 191 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 22, 1920* (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, an- topsy or inquiry.) find that said deceased came to *his* death on the day stated above.
The CAUSE OF DEATH* was as follows:
Railroad wreck (accident)

(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Signed) *J. E. Harrison* (Coroner.) M. D.
May 24, 1920 (Address) *2802 Edmond St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). *40 Days*
At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence *411 N. 23rd St.*

19-PLACE OF BURIAL, OR REMOVAL, *Harpers Ferry W. Va.* DATE OF BURIAL, *May 26, 1920*
20-UNDERTAKER *William Cook* ADDRESS *502 S. North Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43455

D43455

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 41 E. Heath ST.; 23 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Woodburn(Residence in Baltimore: No. 41 E. Heath St. St.; Life yrs., 7 mos., 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male4-COLOR OR RACE White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single6-DATE OF BIRTH, May 16, 1891

(Month) (Day) (Year)

7-AGE, 29 yrs., 7 mos., 29 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 0409-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, John Woodburn11-BIRTHPLACE OF FATHER (State or Country), England12-MAIDEN NAME OF MOTHER, Archie Mead, duff13-BIRTHPLACE OF MOTHER (State or Country), Beth - red.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. W. Rinehart(Address) 41 E. Heath St.

15-

Robert P. Harrison,

MAY 24 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 23, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY That I attended deceased from May 8, 1920, to May 23, 1920, that I saw him alive on May 23, 1920, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 7 yrs., 7 mos., 29 ds.CONTRIBUTORY (Secondary) Influenza(Duration) 1 yr., 7 mos., 29 ds.(Signed) J. F. Harrison M. D.5/24, 1920 (Address) 1 E. Randall

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 7 yrs., 7 mos., 29 ds. In the State 7 yrs., 7 mos., 29 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill CemDATE OF BURIAL, May 25, 192020-UNDERTAKER William CookADDRESS 60286 North, av

Important. See instructions on back of certificate.

D43456

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43456

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. 214* ST. *214* WARD)

2-FULL NAME

Hannah Roth

(a) RESIDENCE. No.

1516 Bayle St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

June 23-1919

7 AGE

Years

11

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md

10 NAME OF FATHER

Jacob Roth

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Emilie Guttsche

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Hospital Record 21.26

15

Issued

MAY 24 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 22 1920

17

I HEREBY CERTIFY, That I attended deceased from

*May 21 1920, to May 22 1920.*that I last saw her alive on *May 22 1920.*and that death occurred, on the date stated above, at *8:00 P. m.*

The CAUSE OF DEATH* was as follows:

Acute suppurative mastoiditis(duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*home*Did an operation precede death? *yes* Date of *5/22/20*Was there an autopsy? *No*What test confirmed diagnosis? *Operation*(Signed) *Harold L. Higgins*, M. D.5/22/20 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cedar Hill Cem.

DATE OF BURIAL

May 25 1920

20 UNDERTAKER

M. J. Flynn

ADDRESS

1422 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *139 W. Hill*)ST.: *22* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Francis Morris

(a) RESIDENCE. No.

*139 W. Hill*ST.: *22* WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs. *10* mos. *23* ds.How long in U. S., If of foreign birth? *10* yrs. *10* mos. *23* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 26 1919

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*10* *23*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Ind*

10 NAME OF FATHER

*John L Morris*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Monrovia, Liberia*

12 MAIDEN NAME OF MOTHER

*Maud Lyon*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Ka: New Orleans*

14

Informant
(Address)*Maud A Morris
139 W. Hill St*

15

Filed *MAY 25 1920**ROBERT E. KRAUTER
Registrar*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5/23/1920

17

I HEREBY CERTIFY, That I attended deceased from
5/20/20 19 *20* to *5/23/1920* 19 *20*
that I last saw h alive on *5/23/1920* 19 *20*and that death occurred, on the date stated above, at *5:15 a* m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(duration) yrs. *4* mos. *4* ds.

CONTRIBUTORY

Acute Bronchitis
(*Secondary*)(duration) yrs. *27* mos. *27* ds.Is Where was disease contracted
If not at place of death?*none*

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical

(Signed)

J. G. Bowley M. D.*5/23/20* (Address)*908 S Sharp St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*W. C. C. Cemetery**5/25/20*

20 UNDERTAKER

Geo A. Joadine 142 W. Hill St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43458

CERTIFICATE OF DEATH.

170 D43458

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 Burgundy ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

8 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

WARD.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than
1 day, ____ hrs.
or ____ min.

70

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Calvert Co Md

10 NAME OF FATHER

Matthew Coates

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Elizabeth West
573 Burgundy ab.

15

MAY 25 1920

ROBERT E. LEADERS

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5/21/1920

17

I HEREBY CERTIFY, That I attended deceased from
May 15th, 1920, to May 21st, 1920,
that I last saw him alive on May 21st, 1920.

and that death occurred, on the date stated above, at 11:57 P.m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial
hepatitis (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

Arterio-sclerosis
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ____

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. Gray M.D. M. D.

5/21/1920 (Address) 908 S. 8th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

National Cem.

May 25 1920

20 UNDERTAKER

John H. Toaderin 42nd St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Charlotte Ross
HEALTH DEPARTMENT—CITY OF BALTIMORE

119 D43459

CERTIFICATE OF DEATH.

79 D43459
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

St.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. (yrs., 8) mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MAY 25 1920

ROBERT E. KRAUTER

BUTLER FIELD

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by and

and that said deceased came to death

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

14 22 1920

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Buderevich(a) RESIDENCE, No. 228 W. Camden St.

(Usual place of abode)

ST. Unknown WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds.How long in U. S., if of foreign birth Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<u>53</u>				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town)
(State or country) Lithuania10 NAME OF FATHER Geo. Buderevich11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia14 Informant Hospital Records
(Address) M.T.H.15 Filed MAY 25 1920 ROBERT B. KRAUTERBurial Forest Hill

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23rd, 1920

17

I HEREBY CERTIFY, That I attended deceased from
April 20, 1920, to May 23, 1920,that I last saw him alive on May 23, 1920,and that death occurred, on the date stated above, at 11.25 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 11 yrs. mos. ds.CONTRIBUTORY Tuberculous laryngitis
(Secondary)(duration) 8 yrs. mos. ds.18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum(Signed) George R. Wilkinson, M.D.5-24-20 Address Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer May 26 1920

20 UNDERTAKER

ADDRESS

John Grebliavskas 425 S. Paca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D43461

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43461

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *105 St. Peter St.*)ST.: *5* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mendle Beloritz

(a) RESIDENCE. NO.

105 St. Peter St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs.

mos.

ds.

How long in U. S., if of foreign birth? *10* yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Mary Beloritz*

6 DATE OF BIRTH (month, day, and year)

May 10 1852

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*68*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Rohhi*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Russia

10 NAME OF FATHER

Moses Chas. Beloritz

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Esther

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant
(Address)*J. Lewis
1411 E. 13 St.*

15

MAY 25 1920

ROBERT E. KRAUTER

Burial Permit 01876

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 23* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

May 17, 19 *20*, to *May 23*, 19 *20*,that I last saw *him* alive on *May 23*, 19 *20*,and that death occurred, on the date stated above, at *3 30* a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(duration) yrs. mos. *7* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical*(Signed) *W. J. B. Smith*, M. D.*5/23/20* (Address) *210 St. John St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Hebrew Cemetery

DATE OF BURIAL

5/25 19 *20*

20 UNDERTAKER

Jack Lewis

ADDRESS

1411 E. 13 St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43462

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

D43462

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1155 E Lombard St ST.; 3 WARD)

2-FULL NAME

Hyman Sherman

(Residence in Baltimore: No. 1155 E Lombard St St.; yrs., 10 mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH

Unknown, 1 (Month) (Day) (Year)

7-AGE,

57 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. School 068
(b) General nature of industry, business, or establishment in which employed (or employer). Teacher

9-BIRTHPLACE, (State or Country),

Russia

PARENTS.

10-NAME OF FATHER,

Joseph Michael

11-BIRTHPLACE OF FATHER (State of Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis
(Address) 1411 E. Balt St

15-

Filed MAY 25 1920 191. ROBERT E. KAUTER
BRIAL 1411 E. Balt St

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 24, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Signed) Sherry Lynn (Duration) ... yrs. ... mos. ... ds. (Address) 1411 E. Balt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew May 25, 1920

20-UNDERTAKER

ADDRESS

Jack Lewis 1411 E. Balt St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43463

CERTIFICATE OF DEATH.

154 D43463

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 S. Robinson St. WARD)

2-FULL NAME

George Maaser

(a) RESIDENCE. NO.

414 S. Robinson St. WARD.

(Usual place of abode) Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Maaser

6 DATE OF BIRTH (month, day, and year) Oct 26-1838

7 AGE Years 81 Months 6 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stable Boss 086

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 10 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER George Maaser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs. Annie Maaser (Address) 414 S. Robinson St.

15 MAY 25 1920 ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1920

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1920, to May 24, 1920, that I last saw him alive on May 24, 1920, and that death occurred, on the date stated above, at 11:48 P. M.

The CAUSE OF DEATH* was as follows:

Senile Debility

CONTRIBUTORY (Secondary)

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. Williams, M. D. , 19 (Address) 160 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Carmel Cemetery May 26 1920

20 UNDERTAKER ADDRESS

H. Vander + Sons 1710 Fleet St.

Physicians should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Dr. Valentine 16 S. Broadway

2046 Eastern

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles Albert Price Jr.

(a) RESIDENCE. No.

Univ. Hosp.

ST.

WARD.

Lakeland Md.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

2

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

7

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 22, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

University Hospital Baltimore Md.

10 NAME OF FATHER

Charles Albert Price

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Florence Ellen Wolf

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Hospital Records University Hospital

15

Filed

MAY 25 1920ROBERT R. EXAMINERSerial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 23, 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 22, 1920, to May 23, 1920that I last saw him alive on May 23, 1920and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity (7 month child)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical Findings(Signed) J. A. Buchness, M. D.19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery May 26, 1920

20 UNDERTAKER

ADDRESS

Wm. Beck 502 E. Pratt St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43466

Madeline M^c Clea Bumgarner
HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

175-

D43466

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Ceremonial Hospital for Cripples & Quakers)

2-FULL NAME

Madeline M^c Clea Bumgarner

(Residence in Baltimore: No. 1424 Mt Royal Ave.)

St. 19 yrs. 8 mos. 26 ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE Single

6-DATE OF BIRTH August 28 1900

7-AGE 19 yrs. 8 mos. 26 ds. or min.?

8-OCCUPATION (a) Trade, profession or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer) none

9-BIRTHPLACE (State or country) Baltimore Md

10-NAME OF FATHER Albert L. Bumgarner

11-BIRTHPLACE OF FATHER (State or country) Pennsylvania

12-MAIDEN NAME OF MOTHER Lillian M^c Clea

13-BIRTHPLACE OF MOTHER (State or country) North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. J. Tucker Taylor

(Address) 2006 Maryland Ave.

15-MAY 25 1920 ROBERT E. KRAUTER

Serial 891 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 24 1920

17- I HEREBY CERTIFY, That I attended deceased from May 20 1920, to May 24 1920, that I saw her alive on May 24 1920, and that death occurred, on the date stated above, at 2:15 p.m.

The CAUSE OF DEATH* was as follows: Fracture of Spine & Paraplegia

Caught under automobile. Aug 2

1919 (Duration) yrs. mos. ds.

Contributory (SECONDARY) Shock during operation for relief of bowel

(Signed) P. J. Tucker Taylor M. D.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death 0 yrs. 0 mos. 4 ds. In the 19 yrs. 8 mos. 26 ds.

Where was disease contracted, if not at place of death? - Md.

Former or usual residence 1424 Mt Royal Ave

19-PLACE OF BURIAL OR REMOVAL Western Cemetery

DATE OF BURIAL May 26 1920

ADDRESS 108 W. NORTH AVE.

UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43467

CERTIFICATE OF DEATH.

154 D43467

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 W. Lafayette, ST.; 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1100 W. Lafayette St.; 68 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-STATUS:
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Widower

6-DATE OF BIRTH

August 22, 1838
(Month) (Day) (Year)

7-AGE

81 yrs., 9 mos., 2 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)Retired Clerk
0099-BIRTHPLACE,
(State or Country).

Baltimore Co. Md.

10-NAME OF FATHER

David Carlisle

11-BIRTHPLACE OF FATHER
(State or Country).

Baltimore Co. Md.

12-MAIDEN NAME OF MOTHER

Math C. Owings

13-BIRTHPLACE OF MOTHER
(State or Country).

Baltimore Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes S. Carlisle(Address) 1100 W. Lafayette Ave.

15-

Filed

MAY 25 1920

ROBERT B. KRAUTER

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 24, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 23 1920, to May 24 1920, that I saw him alive on May 24 1920, and that death occurred, on the date stated above, at 11:40 a.m.

The CAUSE OF DEATH* was as follows:

Old age
+ weakness
(Duration)....yrs....mos....ds.CONTRIBUTORY
(Secondary)Heart failure
(Duration)....yrs....mos....ds.(Signed) Chas. H. Burbert M. D.May 25, 1920 (Address) 1100 W. Lafayette Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

May 26 1920

20-UNDERTAKER

Geo W Little

ADDRESS

531 N. Fremont Ave

Important. See instructions on back of certificate.

D43468

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43468

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21-E-2120 ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 20-E-211 St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

single

6-DATE OF BIRTH

Mar 12, 1836
(Month) (Day) (Year)

7-AGE,

84 yrs. 2 mos. 12 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

MAY 25 1920

ROBERT R. KRAUTER

BOSTON PUBLIC HEALTH DEPARTMENT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 24, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 16 1920, to May 24 1920,that I saw her alive on May 24 1920,and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Heart failuredue to infirmities of age(Duration).....yrs. 1 1/2 mos.ds.

CONTRIBUTORY

(Secondary)

(Duration).....yrs.mos.ds.

(Signed) Wm. J. Watson M. D.May 25, 1920 (Address) 7128 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs.mos.ds. In the State yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington D C May 26, 1920

20-UNDERTAKER

ADDRESS

John Mitchell 207 N. Fayette

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Union Protestant Infirmary

REGISTERED NO. C

CITY OF BALTIMORE: (No.

1514 Division

ST.;

WARD) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Miss Grace Brown

(Residence in Baltimore: No.

Union Protestant Infirmary

St.;

yrs.,

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Single

6-DATE OF BIRTH.

March

16th

1906

(Month)

(Day)

(Year)

7-AGE,

14

yrs.

2

mos.

9

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

School-girl

9-BIRTHPLACE,

(State or Country),

South Carolina

10-NAME OF FATHER,

Wm. M. Brown

11-BIRTHPLACE OF FATHER

(State or Country),

North Carolina

12-MAIDEN NAME OF MOTHER

Gargner

13-BIRTHPLACE OF MOTHER

(State or Country),

North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

G. F. Brown

(Address)

Walhalla, S.C.

15-

MAY 25 1920

ROBERT B. KRAUTER

Filed

191

Burial Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 25th

(Month)

(Day)

1920

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 24th 1920, to May 25th 1920,that I saw her alive on May 25th 1920,and that death occurred, on the date stated above, at 6⁴⁰ A.M.

The CAUSE OF DEATH* was as follows:

Purpura Haemorrhagica

(Duration).....yrs.....mos.

14 ds.

CONTRIBUTORY
(Secondary)

Influenza

(Duration).....yrs.....mos.

1 ds.

(Signed)

J. H. Hines

M. D.

May 25th 1920. (Address) Union Protestant Infirmary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

16 hours

In the

18 hours

of death.....yrs.....mos.....ds.

State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

at home

Former or

usual residence

Walhalla

South Carolina

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Walhalla S.C.

May 25, 1920

20-UNDERTAKER

ADDRESS

Joseph B. Cook

1003 Walhalla

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43470

CERTIFICATE OF DEATH.

D43470

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

1805 Mayland St. 12
Johnson Jones
1805 Mayland Ave

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

Unknown, 1919
(Month) (Day) (Year)

7-AGE,

8 yrs. 8 mos. ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed MAY 25 1920 ROBERT H. ENAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 24, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) M. D.

(Coroner.) May 25, 1920 (Address) 1639 Bayside

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

May 25, 1920

Address

Address

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43471

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

2-FULL NAME

(a) RESIDENCE. NO.

ST.

WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred

61 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5-Single, Married, Widowed,
or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Emma E. Henzel

6 DATE OF BIRTH (month, day, and year)

Nov 16 1858

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.
or min.

61

7

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Shoe cutter

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Factory work

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore and

10 NAME OF FATHER

Casper Henzel

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Agnes Rosh

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Germany

14

Informant

(Address)

Emma E. Henzel (wife)

1624 E. Chase St.

15

MAY 25 1920

ROBERT A. KRAUTER

Baltimore

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 23 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 12, 1920, to May 23, 1920,

that I last saw him alive on May 23, 1920,

and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 11 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

C. D. Needham, M. D.

(Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Church

May 24 1920

20 UNDERTAKER

James B. Byrnes

ADDRESS

1404 Main

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43472

CERTIFICATE OF DEATH.

113

D43472

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

m.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

MAY 25, 1920

ROBERT B. KAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Apr. 22, 1920, to May 24, 1920, that I last saw him alive on May 24, 1920, and that death occurred, on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH* was as follows:

Circosies / liver (Nodular & alcoholic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. M. Elvori, M. D.

19 (Address) H. Joseph H. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D43473

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150
D43473
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Warwick A ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Helen N. Bradley

(a) RESIDENCE. No.

1700 Warwick A ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 12 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town; State or country)

Balto Md.

10 NAME OF FATHER

Irving R Bradley

11 BIRTHPLACE OF FATHER (city or town; State or country)

Va

12 MAIDEN NAME OF MOTHER

Elsie E. Engel

13 BIRTHPLACE OF MOTHER (city or town; State or country)

Balto Md

14

Informant

(Address)

Mrs Elsie E. Bradley

15

File

MAY 25 1920

ROBERT B. KAUTER

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-25-1920

17

I HEREBY CERTIFY, That I attended deceased from May 22, 1920, to May 25, 1920,

that I last saw her alive on May 24, 1920,

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Cyanosis & Congenital cardiac disease

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. C. Conser, M. D.

575 1920 (Address) 1101 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery May 25 1920

20 UNDERTAKER

ADDRESS

C. C. Conser 1101 N Fulton Ave

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43474

CERTIFICATE OF DEATH.

91 D43474

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1913 Walbrooke St* WARD) *15*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *1913 Walbrooke St* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *4* yrs. *4* mos. *4* ds. How long in U. S., if of foreign birth? *4* yrs. *4* mos. *4* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M.* 4 COLOR OR RACE *W* 5 Single, ~~Married~~, ~~Widowed~~, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov 21st 1914*7 AGE Years *5* Months *6* Days *3* If LESS than 1 day, *hrs.* or *min.*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Batts - city* (State or country)10 NAME OF FATHER *Gro. H. Miller*11 BIRTHPLACE OF FATHER (city or town) *Batts - city* (State or country)12 MAIDEN NAME OF MOTHER *Caroline Chaudron*13 BIRTHPLACE OF MOTHER (city or town) *New York City* (State or country)14 Informant *Mrs. Caroline Miller* (Address) *1913 Walbrooke St*15 *MAY 25 1920* *ROBERT B. KAUTER* Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/24/1920*17 I HEREBY CERTIFY, That I attended deceased from *May 18th 1920*, to *May 24th 1920*, that I last saw him alive on *May 24th 1920*, and that death occurred, on the date stated above, at *5:45 P. M.*

The CAUSE OF DEATH* was as follows:

Broncho. Pneumonia(duration) yrs. *6* mos. *6* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. *6* mos. *6* ds.18 Where was disease contracted *Home* if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical*(Signed) *Chas. Jones* M. D., 19 (Address) *2802 Roslyn Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Greenmount Cemetery May 26 1920

20 UNDERTAKER ADDRESS

Isiah Syfer *1609 N. M. St.*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43475

D43475

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland Penitentiary* ST.; *22* WARD)

REGISTERED NO. C

2-FULL NAME

William Dunn

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *Charles St. near Barry* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH

December - 14, 18*84*
(Month) (Day) (Year)

7-AGE,

35 yrs. *5* mos. *4* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*General D4*
Laborer

9-BIRTHPLACE, (State or Country),

North Carolina

PARENTS.

10-NAME OF FATHER,

Bally Dunn

11-BIRTHPLACE OF FATHER (State or Country),

North Carolina

12-MAIDEN NAME OF MOTHER

Ruby Elledon

13-BIRTHPLACE OF MOTHER (State or Country),

North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

John F. Harrison
Maryland Penitentiary

15-

Robert P. Harrison,

UNIVERSITY OF MARYLAND

May 25 1920
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May - 18, 19*20*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *March - 19* 19*20*, to *May - 18* 19*20*, that I saw him alive on *May 9* 19*20*, and that death occurred, on the date stated above, at *12:20* p.m. The CAUSE OF DEATH* was as follows:*Toxemia and Exhaustion*
(Duration)yrs.mos. *7* ds.
CONTRIBUTORY *Milliary Tuberculosis*
(Secondary)
(Duration)yrs.mos. *29* ds.
(Signed) *William F. Schwartz* M. D.
May - 19, 19*20* (Address) *Ind. Penitentiary*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *1* yrs. *2* mos. *21* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Charles near Barry St.*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER
Commissioner Health,

ADDRESS

Per. Wm. S. Woodall

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43476

D43476

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Mumfords Tbe. Hs.* ST. *W* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *512 S. Charter* ST. *W* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1877*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *43*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Brush Maker*(b) General nature of industry, business, or establishment in which employed (or employer) *DB*

(c) Name of employer

9 BIRTHPLACE (city or town) *Delaware* (State or country)10 NAME OF FATHER *John McKee*11 BIRTHPLACE OF FATHER (city or town) *Ireland* (State or country)12 MAIDEN NAME OF MOTHER *Katherine Doyle*13 BIRTHPLACE OF MOTHER (city or town) *Ireland* (State or country)14 Informant (Address) *Hosp. St. Recorder*

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 22 1920*

17 I HEREBY CERTIFY, That I attended deceased from

*January 7, 1920, to May 22, 1920.*that I last saw him alive on *May 22*, 1920.and that death occurred, on the date stated above, at *7* p. m.The CAUSE OF DEATH* was as follows: *Pulmonary Tuberculosis*(duration) yrs. *8* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *not known*Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis? *T.B. in Sputum*(Signed) *George R. Wilkins* M. D., 19 (Address) *Mumfords Tbe. Hs.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND

20 UNDERTAKER

Commissioner Health,

Per. Wm. C. Woodall.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 25 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43472

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2628 McEldary ST.;

WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clinton G. Pasterfield(a) RESIDENCE. No. 2628 McEldary ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1 / 197 AGE Years 1 Months 4 Days 23 LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City10 NAME OF FATHER Jos. W. Pasterfield11 BIRTHPLACE OF FATHER (city or town) (State or country) Md12 MAIDEN NAME OF MOTHER Catherine Kales13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md14 Informant (Address) Jos. G. Pasterfield
2628 McEldary15 May 25 1920 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 192017 I HEREBY CERTIFY, That I attended deceased from May 8, 1920, to May 24, 1920;that I last saw him alive on May 24, 1920, at 3:45 P. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. H. Meyer, M. D.19 (Address) 3241 19th St. & B'n'd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Balto beam,
Philip HenryMay 26 1920
2016
Arlans

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43473

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43478

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *621 N. Glover* ST.: *7* WARD)

2-FULL NAME

Michael Weiss

(a) RESIDENCE. No. *621 N. Glover* ST.: *7* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *53* yrs. *—* mos. *—* ds.

How long in U. S., if of foreign birth? *53* yrs. *—* mos. *—* ds.

REGISTERED NO. *91-081*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept 15/56*

7 AGE

Years

63

Months

8

Days

9

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Truck 086

(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Amey Weiss

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant (Address)

Mrs Morris Slawson 621 N. Glover St.

15 Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 24 1920*

17

I HEREBY CERTIFY, That I attended deceased from

May 12, 1920, to May 24, 1920.

that I last saw him alive on *May 23, 1920.*

and that death occurred, on the date stated above, at *12:30 A.M.*

The CAUSE OF DEATH* was as follows:

Hardening of Arteries

(duration) *7* yrs. *—* mos. *—* ds.

CONTRIBUTORY (Secondary)

Bronchial Pneumonia

(duration) *7* yrs. *—* mos. *—* ds.

18 Where was disease contracted if not at place of death?

in country

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Clinical*

(Signed)

A. C. Beau M. D.

5/27/20 Address *2600 E. Pratt St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Crem. Burn.

DATE OF BURIAL

May 26 1920

20 UNDERTAKER

Phil Hering

ADDRESS

2016 Orleans

MAY 25 1920

D43479

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43479

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.: *8* WARD)2-FULL NAME *Mary Kelly*(a) RESIDENCE. No. *1024 East Chas* ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *64* yrs *7* mos. *21* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct. 3, 1855*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*64**7**21*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balti. Md.*10 NAME OF FATHER *Thomas Patrick*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Ireland*12 MAIDEN NAME OF MOTHER *Hanna Harrison*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Hospital Record Robert P. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 24 1920*

17

I HEREBY CERTIFY, That I attended deceased from *5/22*, 19*20*, to *5/24*, 19*20*.that I last saw him alive on *5/24*, 19*20*.and that death occurred, on the date stated above, at *2.20 p.m.*

The CAUSE OF DEATH* was as follows:

Post Operative Peritonitis

CONTRIBUTORY (Secondary)

Intestinal Obstruction (duration) *5* yrs. *21* mos. *21* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of *1912*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Lucius Q. Ridgely*, M. D.*5/24/20* (Address) *Mary Kelly*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Joseph's Cemetery**5/27, 1920*

20 UNDERTAKER

ADDRESS

Henry W. Mears and Son 805 N. Calvert

Physicians should state exact statement of OCCUPATION. See instructions on back of certificates.

MAY 25 1920

Burial Permit *Class*

D43480

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43480

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *805 West North Ave.* ST. *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Annie L. Roddy

(a) RESIDENCE. NO.

805 West North Ave. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. *40* mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Timothy J. Roddy*

6 DATE OF BIRTH (month, day, and year)

Do not know

7 AGE

Years

Months

Days

If LESS than
1 day, ____ hrs.
or ____ min.*52*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Ireland*

10 NAME OF FATHER

Patrick Leland

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Bridget O'Connor

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant

(Address)

*Thos. Leland**710 E. Biddle St.**Robert P. Harrison,*

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 23rd* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

May 9th, 19*20*, to *May 23rd*, 19*20*.that I last saw her alive on *May 22-*, 19*20*.and that death occurred, on the date stated above, at *10:30 a.m.*

The CAUSE OF DEATH* was as follows:

*Chronic Endocarditis**unknown* (duration) ____ yrs. ____ mos. ____ ds.CONTRIBUTORY
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

if not at place of death?

*unknown*Did an operation precede death? *No* Date of ____Was there an autopsy? *No*What test confirmed diagnosis? *Failure of Emperization*(Signed) *Frederick S. Owen*, M. D., 19 ____ (Address) *2827 N. Calvert St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery May 26 1920

20 UNDERTAKER

ADDRESS

Henry W. Means & Son 805 N. Calvert St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 25 1920

D43481

HEALTH DEPARTMENT--CITY OF BALTIMORE

D43481

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

100 Royal Ave. & Charles st

REGISTERED NO.

CITY OF BALTIMORE: (No.

Montreal Apts.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Emma H. Preston

(a) RESIDENCE, NO.

Montreal Apts.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

5

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

Female

White

Widow

5a If married, widowed, or divorced

(or) WIFE of

D-George J. Preston

6 DATE OF BIRTH (month, day, and year)

Oct 27 = 1863

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

56

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Lacy

(b) General nature of industry,
business, or establishment in
which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Leipzig Germany.

10 NAME OF FATHER

Otho A. Heinrichs

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany.

12 MAIDEN NAME OF MOTHER

Emma Whlig

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany.

14

Informant

(Address)

Margaret J. Preston

Montreal Apts.

15

Filed

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-24

19 20

17

I HEREBY CERTIFY, That I attended deceased from

Tue

1917

to May 24

19 20

that I last saw him alive on

May 24

19 20

and that death occurred, on the date stated above, at 9⁰⁰ m.

The CAUSE OF DEATH* was as follows:

Myocardial infarction
Dilatation of heart

(duration)

3

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

5

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

*Was there an autopsy?

What test confirmed diagnosis?

(Signed)

C. B. Hankley

M. D.

, 19

(Address)

2421 Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cem

5-26

19 20

20 UNDERTAKER

ADDRESS

Hewitt Jenkins & Sons Co

Mc Culloh

Archaed

MAY 25 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43482

D43482

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Elizabeth's Home* ST.; *9* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Sister Mary Anastasia (Anna Teresa Walsh)*(Residence in Baltimore: No. *St. Elizabeth's Home* St.; *68* yrs., *2* mos., *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)

6-DATE OF BIRTH, *March 15*, *1852*.
(Month) (Day) (Year)

7-AGE, *68* yrs., *2* mos., *10* ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),
Cork, Ireland

10-NAME OF FATHER, *Michael Walsh*

11-BIRTHPLACE OF FATHER (State or Country), *Cork, Ireland*

12-MAIDEN NAME OF MOTHER, *Mary Murnhy*

13-BIRTHPLACE OF MOTHER (State or Country), *Cork, Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)....*Mother, Mary Leonard*.....(Address)....*St. Elizabeth's Home*.....15-
Robert P. Harrison,
....., 191.....
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,
May 25, 1920, *191*...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
Apr. 10, 1920, to *May 24, 1920*,
that I saw her alive on *May 23, 1920*,
and that death occurred, on the date stated above, at *6 a. m.*

The CAUSE OF DEATH* was as follows:
Carcinoma of sigmoid

..... (Duration)..... yrs..... mos..... ds.
CONTRIBUTORY.....
(Secondary).....

..... (Duration)..... yrs..... mos..... ds.
(Signed).....*Alfred McKlaun*..... M. D.
May 25, 1920 (Address).....*115 W. Franklin St.*.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Private Cemetery of the Home *May 27, 1920*

20-UNDERTAKER ADDRESS

Henry W. Jenkins & Son Co *McElderry*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 25 1920

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bk

See Affidavit (over.)

D43483

HEALTH DEPARTMENT—CITY OF BALTIMORE

139 D43483

CERTIFICATE OF DEATH

1-PLACE OF DEATH *Mabel Mills Geiss*
CITY OF BALTIMORE: NO. *114 Cole Ave* ST. *26* WARD)
2-FULL NAME *Mabel H. Geiss*
(a) RESIDENCE. NO. *114 Cole Ave* ST. *26* WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred *Life* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced *Married*
6a If married, widowed, or divorced *HUSBAND* (or) WIFE of *George C Geiss*

6 DATE OF BIRTH (month, day, and year) *Apr 22 1891*

7 AGE Years *29* Months *7* Days *1* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At Home*

(b) General nature of industry, business, or establishment in which employed (or employer) *037*

(c) Name of employer

9 BIRTHPLACE (city or town) *Mayland*
(State or country)

10 NAME OF FATHER *M. H. Wells*

11 BIRTHPLACE OF FATHER (city or town) *Mayland*
(State or country)

12 MAIDEN NAME OF MOTHER *Ana R Wells*

13 BIRTHPLACE OF MOTHER (city or town) *Mayland*
(State or country)

14 Informant *Geo C. Geiss*
(Address) *114 Cole Ave*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/23 1920*

17 I HEREBY CERTIFY, That I attended deceased from *5/15*, 19*20*, to *5/23*, 19*20*, that I last saw her alive on *5/23/20* at *6 P.* and that death occurred, on the date stated above, at *6 P.* m. The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. *5* ds.

CONTRIBUTORY *Child Birth*
(Secondary) (duration) yrs. mos. *8* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Sustan A. Post*, M. D.

, 19 (Address) *5/23/20*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Baltimore* DATE OF BURIAL *5/25 1920*

20 UNDERTAKER *William Cook* ADDRESS *501 E. Mt. Vernon*

MAY 25 1920

ROBERT P. HARRISON, Registrar

TELEPHONE:
HAMILTON 881

OFFICE HOURS:
8 TO 10 A. M. 6 TO 8 P. M.
EXCEPT SUNDAY
AND BY APPOINTMENT

DR. GUSTAV A. FRITZ

PHYSICIAN & SURGEON

BELAIR ROAD & MAPLE AVENUE

ONE SQUARE FROM TERMINUS OF CAR LINE

OVERLEA, MD.

1/6/21

To whom it may concern:

This is

to certify that Mrs. Mabel
A. H. Gevine & Mrs. Mabel
Wills Gevine deceased & who
I treated ~~and the same~~ is the
same person.

Gustav A. Fritz, M.D.

Subscribed and sworn to before me this 6th

day of January 1921

Lillian R. Math

Notary Public

D43484

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43481

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1836 N. Chester

ST.:

WARD) 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sarah J. Beever

(a) RESIDENCE. NO.

1836 N. Chester

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

46

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

the late James W. Beever

6 DATE OF BIRTH (month, day, and year)

1836

7 AGE

Years

Months

Days

If LESS than

1 day. hrs.

or min.

84

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Balto md

(State or country)

10 NAME OF FATHER

James W. Beever

11 BIRTHPLACE OF FATHER (city or town)

Md.

(State or country)

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town)

Balto md

(State or country)

14

Informant (Address)

John R. Beever

827 Rutland Ave

15

Filed

Robert P. Harrison,

Registrar

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 23- 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 7, 1920, to May 23, 1920,

that I last saw her alive on May 23, 1920,

and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age.

Just wore out.

no definite disease

(duration) yrs. one mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

no disease

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed)

Wm. J. Watson

M. D.

19 (Address) 7128 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore

May 26 1920

20 UNDERTAKER

Wm. Cook

ADDRESS

502 E. North Ave

Every item of information should be stated EXACTLY. PHYSICIANS should state cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43485

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43485

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *611 St. Ann Ave* ST. *9* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Isaac Benjamin Thompson*(Residence in Baltimore: No. *611 St. Ann Ave* St. *9* yrs. *1* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH

September 12th, 1863
(Month) (Day) (Year)

7-AGE

56 yrs. 5 mos. 31 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Marine 031 Engineer

9-BIRTHPLACE,

(State or Country),

Md.

10-NAME OF FATHER

Thos Thompson

11-BIRTHPLACE OF FATHER

(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Mary Lowmister

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Thompson*(Address) *611 St. Ann Ave*

15-

Filed *Robert P. Harrison*

Registrar.

MAY 25 1920

Bureau Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 25th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*April 26th, 1920, May 25th, 1920,*that I saw him alive on *May 25th, 1920,*and that death occurred, on the date stated above, at *12:30 a.m.*

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation(Duration) *6* yrs. *1* mos. *1* ds.

CONTRIBUTORY

(Secondary)

(Duration) *1* yrs. *1* mos. *1* ds.(Signed) *W. H. Harrison**May 25th, 1920* (Address) *401 E. 25th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *1* mos. *1* ds. In the State *1* yrs. *1* mos. *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Louisa St.

DATE OF BURIAL

May 27th, 1920

20-UNDERTAKER

Wm Cook

ADDRESS

502 E. North Ave

D43486

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D43486

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* ST. *16* WARD)2-FULL NAME *Miss Rokie Daily*(a) RESIDENCE. NO. *908 N. Carey* ST. _____ WARD. _____

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Mar. 20, 1900*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*20**2**4*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Hat Trimmer*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

*Lewis & Clark*9 BIRTHPLACE (city or town)
(State or country)*Georgia*

10 NAME OF FATHER

*Archibald Daily*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Ohio*

12 MAIDEN NAME OF MOTHER

*Clara Ward*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Ga.*

14

Informant
(Address)*Frank Hannah
908 N. Carey St. City*

MAY 25 1920

Robert P. Harrison,

Registrar

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 24 1920*

17

I HEREBY CERTIFY, That I attended deceased from

5/21, 19 *20*, to *5/24*, 19 *20*that I last saw him alive on *May 24*, 19 *20*and that death occurred, on the date stated above, at *4:30 p. m.*

The CAUSE OF DEATH* was as follows:

*Streptococci Toxicities*CONTRIBUTORY
(Secondary)*Streptococci Diphtheria*

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *h* Date of _____Was there an autopsy? *h*

What test confirmed diagnosis?

(Signed)

Wm. D. Ridge M. D.
3/27, 1920 (Address) *Mary Hospital**State the Disease Causing Death, or in death from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Woodlawn**May 27 1920*

20 UNDERTAKER

ADDRESS

*Wm Cook**502 E. North*

Every informant should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43487

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *James Hopkins Hospital* ST.: *110* WARD)

2-FULL NAME

Margaret Smith

(a) RESIDENCE. No.

938 N. Sticker St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

Life

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 5 - 1918

7 AGE

Years

Months

Days

If LESS than

1 day, hrs. or min.

1

9

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Charles Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Elizabeth M. Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

John. Blends

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-25-1920

17

I HEREBY CERTIFY, That I attended deceased from

May 23, 19*20*, to *May 25*, 19*20*,

that I last saw her alive on *May 23*, 19*20*,

and that death occurred, on the date stated above, at *9:30* a. m.

The CAUSE OF DEATH* was as follows

acute encephalitis

(duration)

yrs.

mos.

5 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

ITS Home

Did an operation precede death?

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

clinical

(Signed)

Chas. Taylor

M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore

May 27 1920

20 UNDERTAKER

Wm. Cook

ADDRESS

502 E. North

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43488

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43488

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Baby Truxell.*

(a) RESIDENCE. No. *Baldwin Md.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 25, 1920.*

7 AGE Years Months Days If LESS than 1 day, I day, or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *University Hospital* (State or country) *Baltimore Md.*

10 NAME OF FATHER *James M. Truxell*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Virginia*

12 MAIDEN NAME OF MOTHER *Ella Ruth Swain*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Virginia*

14 Informant *Hospital Records* (Address) *University Hospital.*

15 *Robert P. Harrison,*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 25th* 19 *20*

17 I HEREBY CERTIFY, That I attended deceased from *May 25th*, 19 *20*, to *May 25th*, 19 *20*, that I last saw him alive on *May 25th*, 19 *20*, and that death occurred, on the date stated above, at *10:30 a.m.*

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Clinical Findings*

(Signed) *J. A. Buchness*, M. D.

, 19 (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Fallston (Md.) *May 27* 19 *20*

20 UNDERTAKER ADDRESS

Shirley M. Mowbray
108 Dr. Yorkline
Truxell & Woodson Successors

MAY 25 1920

Burial Permit *Class*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43489

CERTIFICATE OF DEATH.

91-089043489

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1045. Durham ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Dolores Jurelsman

(a) RESIDENCE. No. 1045. Durham ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

June 7-1918

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

11

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

Maryland

10 NAME OF FATHER

Conrad Jurelsman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

Maryland

12 MAIDEN NAME OF MOTHER

Theresa Jurelsman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

Maryland

14

Informant (Address)

Theresa Jurelsman
104 S. Lombard St.

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 18, 1920, to May 24, 1920.

that I last saw her alive on May 23, 1920.

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Broncho-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

findings

(Signed)

F. Fred. Ruzick, M. D.

25, 19 0 (Address) 808 N. Patterson Pl. Bk 120

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cemetery

5/26/20

20 UNDERTAKER

Wendell J. Lippel

ADDRESS

418 E. 21st

MAY 25 1920

D43490

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2305 W. North Avenue ST.: 15 WARD)

2-FULL NAME Barbara Ann Albaugh

(a) RESIDENCE. NO. 2305 W. North Avenue ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 3, 1843

7 AGE 77 Years 3 Months 21 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Do not know (State or country)

10 NAME OF FATHER	Daniel Albaugh
11 BIRTHPLACE OF FATHER (city or town)	Frederick,
(State or country)	Maryland

12 MAIDEN NAME OF MOTHER	Rebecca Miller
13 BIRTHPLACE OF MOTHER (city or town)	Frederick,
(State or country)	Maryland

14 Informant Mrs. Elizabeth W. Newport (Address) 2305 W. North Avenue

15 Filed MAY 26 1920 ROBERT F. FLAUBERT Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1920

17 I HEREBY CERTIFY, that I attended deceased from May 16/20, to May 24, 1920, that I last saw him alive on May 23, 1920, and that death occurred, on the date stated above, at 8:00 a.m.

The CAUSE OF DEATH* was as follows:

Aster. Le lema (Scurvy)

CONTRIBUTORY (Secondary)

(duration) 3+ yrs. mos. ds.

Cardiac Asthma

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. G. Hancock, M. D.

, 19 (Address) 1929 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park Cemetery

5/26 1920

20 UNDERTAKER

ADDRESS

Henry W. Mears & Son 305 W. Calvert

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43491

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 E. Biddle ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Murreyman(a) RESIDENCE. NO. 1011 E. Biddle ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) single5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓6 DATE OF BIRTH (month, day, and year) May 25, 19207 AGE Years Months Days If LESS than 1 day, hrs. or min. 11 29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)10 NAME OF FATHER John T. Murreyman11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland12 MAIDEN NAME OF MOTHER Catherine Brazier13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland14 Informant Catherine Brazier Murreyman (Address) 1011 E. Biddle St.15 MAY 26 1920 ROBERT A. LAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25, 192017 HEREBY CERTIFY, That I attended deceased from May 18th, 1920, to May 25th, 1920, that I last saw her alive on May 25th, 1920, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Cellulitis(duration) yrs. mos. ds. 10CONTRIBUTORY Septicemia (Secondary) Indefinite (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? none(Signed) John T. Logan, M. D.19 (Address) 7 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cemetery

DATE OF BURIAL

5/27 1920

20 UNDERTAKER

Henry W. Mears & Son 805 N. Calvert

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D43492

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43492

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 Gorsuch Avenue

ST.;

WARD)

2-FULL NAME J. Wilson Brown

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 615 Gorsuch Avenue

ST.;

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 1 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Rachel A. Brown

6 DATE OF BIRTH (month, day, and year) April 24, 1838

7 AGE 82 Years 1 Months 0 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired-House Furnish-

(b) General nature of industry, business, or establishment in which employed (or employer) ing Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

10 NAME OF FATHER Abraham Brown

11 BIRTHPLACE OF FATHER (city or town) Pennsylvania
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Jane Hutton

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland14 Informant Wilson Brown
(Address) 615 Gorsuch Avenue

15 MAY 26 1920

ROBERT A. EBAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24, 1920

17

I HEREBY CERTIFY, That I attended deceased from
Dec. 26, 1918, to May 24, 1920,

that I last saw him alive on May 22nd, 1920,

and that death occurred, on the date stated above, at 4:15 A.M.

The CAUSE OF DEATH* was as follows:

Exhaustion & Syncope

(duration) yrs. mos. 3 ds.

CONTRIBUTORY

Arterial Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? High blood pressure and
hardening of arteries

(Signed) J. H. Pillsbury, M. D.

, 19 (Address) 607 E. 27th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Sater's Burying Ground

5/26, 1920

20 UNDERTAKER

ADDRESS

Henry W. Mears & Son 305 N. Calvert

St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Johns Hopkins Hospital* WARD) *6*2-FULL NAME *Margaret Wilson*(a) RESIDENCE. NO. *1905 Lumbly St.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>Colored</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Single</i>
------------------------	-----------------------------------	--

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Single*6 DATE OF BIRTH (month, day, and year) *Nov. 5- 1918*

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<i>2</i>	<i>2</i>	<i>20</i>	

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Child*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*
(State or country) *Ind.*10 NAME OF FATHER *Thomas Wilson*11 BIRTHPLACE OF FATHER (city or town) *Baltimore*
(State or country) *Ind.*12 MAIDEN NAME OF MOTHER *Mary Stewart*13 BIRTHPLACE OF MOTHER (city or town) *Virginia*
(State or country)14 Informant *J. H. H. Bernds*
(Address)15 *MAY 26 1920* *ROBERT E. ELAUTE*
Registrar
Burial Permit Clerk

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 24 1920*

17 I HEREBY CERTIFY, That I attended deceased from
May 19-, 19*20*, to *May 24*, 19*20*,
that I last saw her alive on *May 24*, 19*20*,
and that death occurred, on the date stated above, at *1 a.m.*

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis(duration) yrs. *2* mos. ds.CONTRIBUTORY
(Secondary)(duration) yrs. *?* mos. ds.18 Where was disease contracted
if not at place of death? *At home*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *W. H. H. H. H.* M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43494

CERTIFICATE OF DEATH

120 D43494
REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.

229 N. Bond St.

WARD) 6

2-FULL NAME

John Wells

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

3-RESIDENCE IN BALTIMORE: No.

229 N. Bond St.

20 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

Col.

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

Not known

(Month) (Day) (Year)

7-AGE

50

— yrs. — mos. — ds. or min.?

If LESS than
1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

040

9-BIRTHPLACE
(State or country)

Oklahoma

10-NAME OF FATHER

Not known

11-BIRTHPLACE OF FATHER
(State or country)

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER
(State or country)

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Burah E. Elliott

(Address)

1725 Ashland Ave

15-

MAY 26 1920

ROBERT R. ELLAUER

BURIAL PLACE

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May 23, 1920

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 15, 1920, to, May 23, 1920,

that I saw him alive on May 22, 1920,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Chr Brights-Haematoma

(Duration) Not known yrs. mos. ds.

Contributory
(SECONDARY)

Chorea

(Duration) 3 yrs. mos. ds.

(Signed), Dr. Reder M. D.

May 25, 1920, [Address] 1904 E. Ray St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Laurel Co

DATE OF BURIAL

May 24, 1920

20-UNDERTAKER

R. A. Elliott

ADDRESS

1725 Ashland Ave

1827th July

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

043496

CERTIFICATE OF DEATH.

182 043496

PLACE OF DEATH
CITY OF BALTIMORE (No. *10 Joseph H. Hopper St.* WARD) (If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Samuel Rouse*
(Residence in Baltimore: No. *1421 Maryland Ave* St. *40* yrs. *40* mos. *40* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *Col.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married* (Write the word.)
6-DATE OF BIRTH, *July 120*, *1880*
(Month) (Day) (Year)

7-AGE, *32* yrs. *8* mos. *25* ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Clerk*
(b) General nature of industry, business, or establishment in which employed (or employer). *074*

9-BIRTHPLACE (State or Country). *South Carolina*

10-NAME OF FATHER. *William Rouse*

11-BIRTHPLACE OF FATHER (State or Country). *So. C.*

12-MAIDEN NAME OF MOTHER. *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country). *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lizzie Rouse*

(Address) *1421 Maryland Ave*

15- *MAY 26 1920* *ROBERT A. KRAUTER*

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH, *May 25*, *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

the body and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide by
John H. Hopper
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *John H. Hopper* (Coroner)

191... (Address) *1421 Maryland Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. *Abwick So. C.* DATE OF BURIAL, *May 26, 1920*

20-UNDERTAKER *George H. Holland* ADDRESS *1631 Bridge Hill Ave*

Physicians should state EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Blanc. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43497

CERTIFICATE OF DEATH.

152 D43497

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 N. Curley ST.; 7 WARD)

2-FULL NAME

(a) RESIDENCE. No. 508 N. Curley ST., 7 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25, 1920

7 AGE Years Months Days If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER John B. Kaufman

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Mary Cath. Borch

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant (Address) Jno. B. Kaufman 508 N. Curley St.

15 MAY 26 1920 ROBERT B. CRAMER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1920

17

I HEREBY CERTIFY, That I attended deceased from May 25, 1920, to

that I last saw him alive on May 25, 1920,

and that death occurred, on the date stated above, at 4:20 P. M.

The CAUSE OF DEATH* was as follows:

Insymptomatic Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Collapse (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Keos M. D.

6/15, 1920 (Address) 413 N. Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer.

MAY 26 1920

20 UNDERTAKER

ADDRESS

Geo. M. Fink & Son,

811 N. Wolfe

Burial Permit Clerk

Funeral Directors & Embalmers.

D43498 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D43498

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *920 Light*ST.: *23* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Conrad Ackermann*(a) RESIDENCE. No. *920 Light*

ST.: _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *56* yrs. — mos. — ds.How long in U. S., if of foreign birth? *56* yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Male**White**Widowed*

5a If married, widowed, or divorced

HUSBAND of *Annie Ackermann*6 DATE OF BIRTH (month, day, and year) *May 4 1846*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*74**—**21*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Packer

(b) General nature of industry, business, or establishment in which employed (or employer)

Drug House

(c) Name of employer

Sharp & Dohme

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

(Address)

*Mrs. Elizabeth Williams**920 Light St*

15

FILE

*MAY 26 1920**ROBERT F. ERAUTER**BRIAL PERMIT CITY*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 24 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*May 17, 1920, to May 24, 1920,*that I last saw him alive on *May 24, 1920,*and that death occurred, on the date stated above, at *7:30 P. M.*

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver (Biliary)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *No*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *F. Edward Smith, M. D.**Apr. 20 (Address) 910 Light St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*MOUNT OLIVE**MAY 27 1920*

20 UNDERTAKER

ADDRESS

*JOHN F. DENNY**715 LIGHT ST*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE ⁹¹

D43499

CERTIFICATE OF DEATH.

6-0 D43499

1-PLACE OF DEATH

CITY OF BALTIMORE: ^{3903 Greenmount Ave} ST. ⁹ WARD)

2-FULL NAME

(Residence in Baltimore: No. ^{3903 Greenmount Ave} St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH.

Aug-9-

1917

7-AGE,

2 yrs. 9 mos. 16 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE,

(State or Country),

Balto City

10-NAME OF FATHER,

Geo. Noback

11-BIRTHPLACE OF FATHER

(State or Country),

Balto Md

12-MAIDEN NAME OF MOTHER

Annie Braumbach

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Annie Noback

(Address)

15 Elm St

MAY 26 1920

ROBERT H. KRAUTER

Filed

191

BOSTON

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 25th 1920

17- I HEREBY CERTIFY, That I attended deceased from

May 22 1920, to May 25 1920,

that I saw her alive on May 25 1920,

and that death occurred, on the date stated above, at 3³⁰ p. m.

The CAUSE OF DEATH* was as follows:

Measles

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY

Broncho-Pneumonia

(Secondary).....yrs.....mos.....ds.

(Signed)

John S. Freely, M. D.

5726

1920 (Address) 3542 Greenmount Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Cross Cem.

DATE OF BURIAL,

5-26-1920

20-UNDERTAKER

E. B. Noble

ADDRESS

155 West 88

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43500

CERTIFICATE OF DEATH.

D43500

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 McKean ave ST.: 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1907 McKean ave St.: 9 yrs. 6 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED, Married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

April 7, 1840
(Month) (Day) (Year)

7-AGE,

80 yrs. 1 mos. 17 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife
at home9-BIRTHPLACE,
(State or Country),md.

10-NAME OF FATHER,

George Flagle11-BIRTHPLACE OF FATHER
(State or Country),md.

12-MAIDEN NAME OF MOTHER

Lydia Frank13-BIRTHPLACE OF MOTHER
(State or Country),md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Levin Myers(Address) 1907 McKean ave15-
MAY 26 1920

Filed....., 191.....

ROBERT B. KAUTER

Burial Permitted

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 24, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Nov. 1 1919, to May 24 1920,
that I saw her alive on May 24 1920,
and that death occurred, on the date stated above, at 8 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency(Duration).....yrs. 6 mos.ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.mos.ds.

(Signed) R. C. Metzel M. D.May 26, 1920 (Address) 1907 McKean ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.mos.ds. In the State.....yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence Westminster Md

19-PLACE OF BURIAL OR REMOVAL,

Claremont Valley Md.

DATE OF BURIAL,

May 27, 1920

20-UNDERTAKER

H. M. Routrou

ADDRESS

2238 N. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1090 Bks.

140959
D43501

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 17th WARD)

2-FULL NAME

Elwood Gordon

(a) RESIDENCE. No.

1024 Pennsylvania Ave

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

Life mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

+

6 DATE OF BIRTH (month, day, and year)

Nov. 19 - 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

6 mos

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

John Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Tenn.

12 MAIDEN NAME OF MOTHER

Eleanora Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind.

14

Informant (Address)

J. H. H. Records

15

MAY 26 1920

ROBERT A. KRAUTER
Registrar
Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 25 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 17, 1920, to May 25, 1920;

that I last saw him alive on May 25, 1920,

and that death occurred, on the date stated above, at 4:00 a m.

The CAUSE OF DEATH* was as follows:

General Military Tuberculosis

CONTRIBUTORY (Secondary)

(duration) 12 mos. yrs. mos. ds.

(duration) 20 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Patent Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. H. H. H. M. D.

, 19 (Address) 1111

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Luke

May 26th 1920

20 UNDERTAKER

Sam. H. Chase - son

ADDRESS
1400 N. Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43502

D43502

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Murray Hospital* ST. *5* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *2436 Walbrook Ave* ST. *5* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Male**White**Married*

5a If married, widowed, or divorced

HUSBAND of *Don't know wife's name.*
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *May 23-1853*

7 AGE

Years

Months

Days

If LESS than
1 day, ____ hrs.
or ____ min.*67**2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto*
(State or country) *md*10 NAME OF FATHER *Jacob Riehl*11 BIRTHPLACE OF FATHER (city or town)
(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Don't know*13 BIRTHPLACE OF MOTHER (city or town)
(State or country) *Don't know*

14

Informant *Sda Gulderson*
(Address) *2036 Walbrook Ave*

15

*MAY 26 1920*ROBERT E. FRADTER
Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 25 1920*

17

I HEREBY CERTIFY, That I attended deceased from

May 18 1920, to *May 25 1920*.that I last saw him alive on *May 25 1920*.and that death occurred, on the date stated above, at *6:30 P.* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach(duration) ____ yrs. *6* mos. ____ ds.CONTRIBUTORY
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *D. O. Ridgely* M. D.per *Don't know* *mercy* *opp*
19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**May 31 1920*

20 UNDERTAKER

William Cook

ADDRESS

522 S. North Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S NAME and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43503
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

28 D43503
REGISTERED NO.

CITY OF BALTIMORE: (No. 416 South Payson ST. 20 WARD)

2-FULL NAME Robert J. Dummavant

(a) RESIDENCE. NO. 416 S. Payson ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE Male White

5 Single Married, Widowed, Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Dummavant

6 DATE OF BIRTH (month, day, and year) Nov 25/1876

7 AGE

Years 43

Months 6

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Presser 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER R. J. Dummavant

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Mary Thompson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14

Informant (Address) Ethel Dummavant 416 S. Payson ST.

15

MAILED MAY 26 1920

Barial Permit 04078

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1920

17

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1920, to May 25, 1920.

that I last saw him alive on May 25, 1920.

and that death occurred, on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Gangrene of Extremities (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? I don't know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Joseph E. Morse, M. D.

, 19 (Address) 1520 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park 5/28/20

20 UNDERTAKER ADDRESS

Wm Cook 502 E. N. St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43501

CERTIFICATE OF DEATH.

120 D43501
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1578 Clifton Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vane Ebargh Stout

(Residence in Baltimore: No. 2623 Woodbrook Ave.

St.; 2 yrs. 1 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male 4-COLOR OR RACE. white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. married (Write the word.)

6-DATE OF BIRTH. July 23, 1890 (Month) (Day) (Year)

7-AGE, 29 yrs. 10 mos. 2 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. carpenter 015 (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Md.

10-NAME OF FATHER, Geo. W. Stout

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Carrie V. Ebargh

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. H. Sisco

(Address) 1315 N. Chase St.

15- MAY 26 1920 191. ROBERT E. BRAUTER

Burial Place

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 25, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20 1920, to May 25 1920, that I saw him alive on May 25 1920, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows: Nephritis, Chronic, Interstitial (scurvy) (Duration) 2 yrs. 10 mos. 2 ds.

CONTRIBUTORY (Secondary)

(Signed) J. H. Sisco M. D. 5/26, 1920 (Address) 1315 N. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park DATE OF BURIAL, May 29, 1920

20-UNDERTAKER, William Cook ADDRESS, 502 E. North Ave.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

92-043505

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 4036 Park Heights ST., 1 WARD.

(Usual place of abode) _____ (If nonresident give city or town and State) _____
Length of residence in city or town where death occurred 45 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? 45 yrs. _____ mos. _____ ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 24* 19*20*

HUSBAND of
(or) WIFE of

HUSBAND of
(or) ~~WIFE~~ of *widow the Charles H. Wright.*

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46				

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town).....Germany
(State or country)

10 NAME OF FATHER *Anton Alger*

11 BIRTHPLACE OF FATHER (city or town) *Germany*
(State or country)

12 MAIDEN NAME OF MOTHER *Don't know*

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Emma E. Wright
(Address) 244 N. 1st St. S.

15 Filed MAY 26 1926 ROBERT E. LEAUTEK Registrar

17

17 I HEREBY CERTIFY, That I attended deceased from
May 17, 1930, to May 24, 1930

that I last saw him alive on May 24 1920

and that death occurred, on the date stated above, at 8²⁰ P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
right side. -

(duration) mos. 7 d.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? *Do not know.*

Did an operation precede death? *No* Date of *—*

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Physical examination*

(Signed) W. B. Brown and K. H. K. K. M. D.

5/25, 1920 (Address) 626 W. Pioneer St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
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London Park May 27 192

20 UNDERTAKER	ADDRESS
William Cook.	502 E. North

of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAY 26 1920

ROBERT A. KAUTER

Registrar

Notary Public

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

May 24, 1920, to May 25, 1920,

that I last saw him alive on May 25, 1920,

and that death occurred, on the date stated above, at 7:45 P. M.

The CAUSE OF DEATH* was as follows:

Cholecystitis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. D. Ridgely

M. D.

5-25-20 Address

Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

William Cook

ADDRESS

502 E. North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43507

CERTIFICATE OF DEATH.

170 D43507

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3233 - Fleet St.; 26th WARD)

2-FULL NAME

(Residence in Baltimore: No. 3233 - Fleet St.; 30 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M 4-COLOR OR RACE, W 5-STATUS, Married

6-DATE OF BIRTH, 31, 1858 (Month) (Day) (Year)

7-AGE, 62 yrs., 1 mos., 25 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Cooper 86 (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Frank M. Gorman

10-NAME OF FATHER, Frank M. Gorman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary A. Dossel

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Robert P. Harrison

(Address), 3233 Fleet St.

15-

Filed, Robert P. Harrison, Registrar.

MAY 26 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 5, 24, 1920 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from 4/11/20 191, to 5/24/20 191, that I saw him alive on 3/24/20 191, and that death occurred, on the date stated above, at 11:30 pm.

The CAUSE OF DEATH* was as follows: Oedema of lung.

CONTRIBUTORY (Secondary), Chronic indurated nephritis

(Signed), J. H. Gorman, 5/25/20 (Address), 3233 Fleet St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, May 27, 1920

20-UNDERTAKER, J. H. Gorman

ADDRESS, 2008 Orleans

D43508

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43508

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3023 Montebello Ave ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John J. Driver

(a) RESIDENCE. NO.

3023 Montebello Ave ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Lucie Driver

6 DATE OF BIRTH (month, day, and year)

Sept 8, 1864

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

55816

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Kennedy Iron Foundry

9 BIRTHPLACE (city or town) (State or country)

BaltMd.

10 NAME OF FATHER

Charles F. Driver

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Not known

14

Informant

(Address)

Lucie Driver3023 Montebello Ave

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 1, 1920, to May 24, 1920,that I last saw him alive on May 24, 1920,and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma Kidney(duration) 3+ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of April 20thWas there an autopsy? noWhat test confirmed diagnosis? microscopic(Signed) Frederic J. Kingley, M. D.5/15, 1920 (Address) 2700 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London ParkMay 27 1920

20 UNDERTAKER

ADDRESS

H. Sander Loux1200 Park

MAY 26 1920

Burial Permit Clerk.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D43509

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43509

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 635 E. Lombard ST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Marie Hinnors(a) RESIDENCE, No. 635 E. Lombard ST. 3 WARD. 3
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Unknown yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Hinnors6 DATE OF BIRTH (month, day, and year) Jan. 29 - 18297 AGE Years 91 Months 3 Days 25 If LESS than 1 day, 0 hrs. 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Henry Hinnors(Address) 635 E. Lombard St.
Robert P. Harrison,

MAY 26 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May, 24th, 192017 I HEREBY CERTIFY, That I attended deceased from for many yrs. 1920, to him of 24 1920, that I last saw him alive on 23 at May 1920, and that death occurred, on the date stated above, at 6 P. M. The CAUSE OF DEATH* was as follows:
Pulmonary Tubercl.(duration) 4 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 24Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank O. Hinnors M. D., 19 (Address) 1500 Rutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery.5/27 1920

20 UNDERTAKER

ADDRESS

C. F. Evans & Son 118 W. Mt. Royal Av.

Information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43510

151 D43510

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Barth

(a) RESIDENCE. No.

2607 E. Monument

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, 5 hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

MD

10 NAME OF FATHER

William Barth

11 BIRTHPLACE OF FATHER (city or town) (State or country)

MD

12 MAIDEN NAME OF MOTHER

Anna Cerny

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MD

14

Informant (Address)

E. E. Duncan
Johns Hopkins Hospital

15

Filed

Robert P. Harrison,

Registrar

176 MAY 26 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 21 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 20, 1920, to May 21, 1920,

that I last saw him alive on May 21, 1920,

and that death occurred, on the date stated above, at 2:20 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.
Maternal Eclampsia

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) John W. Harris, M. D.

522 1920 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Comptroller General

May 25 1920

(Panczynski)
HEALTH DEPARTMENT—CITY OF BALTIMORE

D43511

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 S. Glover ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 818 S. Glover St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

Sept 14, 1920
(Month) (Day) (Year)

7-AGE,

8 yrs. 11 mos. ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

Frank Panczynski

11-BIRTHPLACE OF FATHER
(State or Country),

Poland

12-MAIDEN NAME OF MOTHER

Rosa Janikowski

13-BIRTHPLACE OF MOTHER
(State or Country),

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosa Panczynski

(Address) 818 S. Glover St.

15-

Filed MAY 26 1920 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 25, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 23, 1920, to May 25, 1920,

that I saw her alive on May 25, 1920,

and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Bronch. Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. M. D.

May 26, 1920. (Address) 165 S. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Rosary Cem May 27, 1920

20-UNDERTAKER

ADDRESS

Stephen Fallowski 1008 ...

Burial Permit 3144

D43512

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43512

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Royston + Euclid* ST.: *27* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Royston + Euclid* St.: *15* yrs., *8* mos., *18* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*white*5-SINGLE, MARRIED, *single*, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH.

Sept 7, 1904
(Month) (Day) (Year)

7-AGE.

15 yrs., *8* mos., *18* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....*None*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country).

Maryland

10-NAME OF FATHER.

William Dawson

11-BIRTHPLACE OF FATHER (State or Country).

Virginia

12-MAIDEN NAME OF MOTHER

Laura Sullivan

13-BIRTHPLACE OF MOTHER (State or Country).

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*Mrs. Connolly*(Address).....*Fullerton*

15-

*Robert P. Harrison,**May 26 1920* Burial Permit clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 25, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 1920*, to *May 25 1920*, that I saw her alive on *May 24 1920*, and that death occurred, on the date stated above, at *11:52* m.

The CAUSE OF DEATH* was as follows:

Chronic intestinal obstruction
of pancreas
(Duration).....*4* yrs., *4* mos., *4* ds.

CONTRIBUTORY (Secondary)

Suppurative appendicitis
(Duration).....*4* yrs., *4* mos., *4* ds.(Signed).....*Geary A. Long* M. D.*May 25, 1920* (Address).....*774 Fullerton*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....*4* yrs., *4* mos., *4* ds. In the State.....*4* yrs., *4* mos., *4* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.

Parkwood Cemetery

DATE OF BURIAL.

May 25, 1920

20-UNDERTAKER

Mrs. J. Condes

ADDRESS

774 Fullerton St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43513

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43513

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 Park Ave ST.; WARD) 4

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Jenkins Sturdivant(a) RESIDENCE. No. 409 Park Ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Aug 15 - 18477 AGE Years 72 Months 8 Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Penn
(State or country) Pa10 NAME OF FATHER John Sturdivant11 BIRTHPLACE OF FATHER (city or town) W. Va
(State or country)12 MAIDEN NAME OF MOTHER Katherine Kuffner13 BIRTHPLACE OF MOTHER (city or town) Penn
(State or country) Pa14 Informant Miss Ellen Jenkins
(Address) 409 Park Ave15 Filled Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 192017 I HEREBY CERTIFY, That I attended deceased from May 15, 1920, to May 26, 1920, that I last saw alive on May 26, 1920, and that death occurred, on the date stated above, at 10:30 am. The CAUSE OF DEATH* was as follows:Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY do not know
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted 409 Park Ave
If not at place of death?Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Physician's Exam(Signed) Rd. Keyser, M. D., 19 (Address) Wentworth St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem DATE OF BURIAL May 28 192020 UNDERTAKER Jenkins & SonsADDRESS 409 Park Ave

MAY 26 1920

Burial Permit Clerk.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43514

CERTIFICATE OF DEATH.

D43514

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *135 S. Spring Street* ST. *3* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Rosa Resnick*(a) RESIDENCE. NO. *135 S. Spring St* ST. _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *19* yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? *19* yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>white</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>married</i>
------------------------	---------------------------------	--

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____6 DATE OF BIRTH (month, day, and year) *Unborn 1888*

7 AGE	Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
	<i>32</i>	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Russia*10 NAME OF FATHER *Israel Kaplan*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Russia*12 MAIDEN NAME OF MOTHER *Bessie Kaplan*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Russia*

14

Informant
(Address)*J. Lewis
1411 S. Balto St*

15

MAY 27 1920

ROBERT F. KRAUTER
Registrar

Social Security Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 26, 1920*

17

I HEREBY CERTIFY, That I attended deceased from *April 25, 1920* to *May 26, 1920*, that I last saw her alive on *May 26, 1920*, and that death occurred, on the date stated above, at *8 P* m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis
Subacute Tonsillitis
Chronic Cardiac Hypertrophy & Dilatation

(duration) yrs. *3* mos. _____ ds.CONTRIBUTORY *Acute Pericarditis*
(Secondary)(duration) yrs. _____ mos. *1* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date of _____Was there an autopsy? *No*What test confirmed diagnosis? *Physical signs, hist & lab*(Signed) *M. B. Lewis* M. D.19 (Address) *The Walbert*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Hebrew Herring Bur.**5/27 1920*

UNDERTAKER

ADDRESS

*Jack Lewis**4118 Bal*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43515

D43515

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 Greenmount ST.; 10 WARD)

2-FULL NAME

Harold W Greenberg

(a) RESIDENCE. No.

713 Greenmount ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 5 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore
USA

10 NAME OF FATHER

Leon Greenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country)

New York

12 MAIDEN NAME OF MOTHER

Mollie Goldstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russian

14

Informant (Address)

2 Greenberg - 709 Astor

15

MAY 27 1920

ROBERT H. KAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1920

17

I HEREBY CERTIFY, That I attended deceased from May 25, 1920, to May 26, 1920, that I last saw him alive on May 26, 1920, and that death occurred, on the date stated above, at 8 A. m. The CAUSE OF DEATH* was as follows:

Capillary
Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. J. Saper, M. D.

5/27, 1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Bellevue Memorial Home May 27 1920

20 UNDERTAKER

ADDRESS

Jack Lewis, 1411 E. Pratt

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19-H. P. Co.-1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 42 E. Forrest Avenue, Raspburg ST.: 26 WARD)

2-FULL NAME

GEORGE THOMAS,

(a) RESIDENCE. No. 42 E. Forrest Avenue, Raspburg ST., 26 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. - mos. - ds. How long in U. S., if of foreign birth? 63 yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Thomas

6 DATE OF BIRTH (month, day, and year) Oct. 2, 1845

7 AGE Years 74 Months 7 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker (retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hesse Darmstadt (State or country) Germany

10 NAME OF FATHER Henry Thomas

11 BIRTHPLACE OF FATHER (city or town) Zurigen (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Happel

13 BIRTHPLACE OF MOTHER (city or town) Wahnen (State or country) Germany

14 Informant Emelia Rasch (Address) 42 Forrest Ave. Raspburg

15 MAY 27 1920 ROBERT F. FAUTER Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1920

17 I HEREBY CERTIFY, That I attended deceased from

August 4, 1918 to May 26, 1920

that I last saw him alive on May 25, 1920

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 2 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) - yrs. - mos. 1 ds.

18 Where was disease contracted * * * If not at place of death?

Did an operation precede death? no Date of * * *

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Edw. M. Simpson M. D.

5/26 1920 (Address) 5 N. Washington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Immanuel Cemetery

May 28 1920

20 UNDERTAKER

ADDRESS

Fredk. Asa...

Edmonton Int.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43517

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 1 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 1000 ST. 1 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

REGISTERED NO. D43517
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Baltimore Md.

(If nonresident give city or town and State)

Yrs.

Mos.

Ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female
Caucas
5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Perry Johnson

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

MAY 27 1920

ROBERT A. CRUTTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May - 24 1920

17

I HEREBY CERTIFY, That I attended deceased from
May 23, 1920, to May 24, 1920,
that I last saw her alive on May 24, 1920,
and that death occurred, on the date stated above, at 5 PM m.
The CAUSE OF DEATH* was as follows:
over

Idiopathic
Tetanus
(duration) yrs. mos. ds. 21

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? at home address

Did an operation precede death? NO Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum and Cere
(Signed) Wm. Flew M. D.

Address University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Union Chapel Co.

May 27 1920

20 UNDERTAKER

ADDRESS

Sam. Hunsley

578 N. E. Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

043518

043518

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1347 Carroll St. ST. 21 WARD)

2-FULL NAME Ida Butler

(a) RESIDENCE. NO. 1347 Carroll St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds.

How long in U. S. If of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female Colored

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAY 27 1920

ROBERT B. FRATER Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-24-1920

17

I HEREBY CERTIFY, That I attended deceased from May 20, 1920, to May 24, 1920, that I last saw him alive on May 24, 1920, and that death occurred, on the date stated above, at 8:15 p.m. The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos. ds. 2

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 2

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. L. L. L. M. D.

, 19 (Address) 1227 Cumberland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

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143519
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143519
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PARENTS

N. R.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

043519

6-091 043519

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *12* WARD)

2-FULL NAME *Ernest Walter*

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. *Monkton Co Rd* ST. _____ WARD. *Monkton Md*
(Usual place of abode)

Length of residence in city or town where death occurred yrs. *3* mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Child</i>
5a If married, widowed, or divorced HUSBAND of (or) WIFE of <i>Child</i>		
6 DATE OF BIRTH (month, day, and year) <i>Sept - 1914</i>		
7 AGE <i>5</i> Years	Months <i>8</i>	Days <i>8</i>
If LESS than 1 day, _____ hrs. or _____ min.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) *Md.*
(State or country)

10 NAME OF FATHER <i>Andrew J. Walter</i>
11 BIRTHPLACE OF FATHER (city or town) <i>Md.</i> (State or country)
12 NAME OF MOTHER <i>Marsha</i>
13 BIRTHPLACE OF MOTHER (city or town) <i>Md.</i> (State or country)

Informant *Hospital Record*
(Address) *27th St.*

15 MAY 27 1920 ROBERT A. LAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 26 1920*

17 I HEREBY CERTIFY, That I attended deceased from *May 24*, 1920, to *May 26*, 1920, that I last saw him alive on *May 26*, 1920, and that death occurred, on the date stated above, at *3:09 a. m.*

The CAUSE OF DEATH* was as follows:
Measles

(duration) _____ yrs. _____ mos. *12* ds.
CONTRIBUTORY *Bronchopneumonia*
(Secondary) (duration) _____ yrs. _____ mos. *5* ds.

18 Where was disease contracted if not at place of death? *?*

Did an operation precede death? *No* Date of _____

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Autopsy*

(Signed) *Harold L. Stegman* M. D.
5/26 1920 Address) *Johns Hopkins Hosp*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL <i>Monkton Md</i>	DATE OF BURIAL <i>May 27 1920</i>
20 UNDERTAKER <i>Daniel Earls</i>	ADDRESS <i>P.O. Box</i>

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43520

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2803 Bernard* ST.; *12* WARD)

2-FULL NAME

(Residence in Baltimore: No. *2803 Bernard* St.; *1* yrs., *10* mos., *28* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) *Single*

6-DATE OF BIRTH,

June 28, 1915
(Month) (Day) (Year)

7-AGE,

10 28
yrs. mos. ds.If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *nurse*
(b) General nature of industry, business, or establishment in which employed (or employer). *poor*9-BIRTHPLACE,
(State or Country),*Buenos Aires*

10-NAME OF FATHER,

*C. H. Jefferys*11-BIRTHPLACE OF FATHER
(State or Country),*md*

12-MAIDEN NAME OF MOTHER

*Rosa Ayers*13-BIRTHPLACE OF MOTHER
(State or Country),*md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rosa Jefferys*(Address) *2803 Bernard*

15-

Filed *MAY 27 1920*

ROBERT H. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 26, 1920
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Feb 12, 1920*, to *May 26, 1920*, that I saw him alive on *July 21, 1920*, and that death occurred, on the date stated above, at *4 45* p.m.

The CAUSE OF DEATH* was as follows:

Tubercular meningitis
(Duration) ... yrs. ... mos. *4* ds.CONTRIBUTORY
(Secondary)(Signed) *C. H. Jefferys* M. D.
5-27-20, 1920 (Address) *3701 Paine St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Marys Hospital *5/28, 1920*

20-UNDERTAKER

ADDRESS

J. Walter Davis *3307 Paine St*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43521

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent's Infant Asylum* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1401 Division St.* St.; *4* yrs., *4* mos., *4* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

May 20, 1920
(Month) (Day) (Year)

7-AGE.

4 yrs., *4* mos., *4* ds.

If LESS than 1 day.

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE.
(State or Country).*Maryland*

10-NAME OF FATHER.

*John Henry Ramsey*11-BIRTHPLACE OF FATHER
(State or Country).*Virginia*

12-MAIDEN NAME OF MOTHER.

*Elizabeth Patter*13-BIRTHPLACE OF MOTHER
(State or Country).*Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

St. Vincent's Inf. Asylum

(Address).

1401 Division St.

15-

MAY 27 1920

ROBERT H. KRAUTER

Filed.

191...

Baptist Church

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 24, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 20, 1920, to May 23, 1920*that I saw him alive on *May 23, 1920*and that death occurred, on the date stated above, at *19* m.

The CAUSE OF DEATH* was as follows:

Primary Cause: Unknown

.....

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)*Convulsions*

..... (Duration)..... yrs..... mos..... ds.

(Signed).

Chas. H. H. H.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

Catholic Church

DATE OF BURIAL.

May 27, 1920

20-UNDERTAKER

North Street

ADDRESS

1827 W North

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-1914—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *12* WARD)

2-FULL NAME *Harothy Andrew*

(a) RESIDENCE. NO. *Easton, Md* ST. *Easton Md.* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. *25* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Child*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Child*

6 DATE OF BIRTH (month, day, and year) *Jan 6 - 1920*

7 AGE Years *5* Months *21* Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Maryland* (State or country)

10 NAME OF FATHER *Herbert Andrew*

11 BIRTHPLACE OF FATHER (city or town) *Maryland* (State or country)

12 MAIDEN NAME OF MOTHER *Edith White*

13 BIRTHPLACE OF MOTHER (city or town) *Maryland* (State or country)

14 Informant *Hospital Record* (Address) *St. 76.*

15 *MAY 27 1920* **ROBERT A. KAUTER** Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 26 1920*

17 I HEREBY CERTIFY, That I attended deceased from *May 1*, 1920, to *May 26*, 1920, that I last saw her alive on *May 26*, 1920, and that death occurred, on the date stated above, at *11:30* a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. *2* mos. ds.

CONTRIBUTORY (Secondary) *none*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *home*

Did an operation precede death? *No* Date of

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Physical signs* (Signed) *Harold L. Higgins*, M. D.

5/26/20 Address *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Easton - Md

May 27 1920

20 UNDERTAKER

William Cook

ADDRESS *503 S. North*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43523

CERTIFICATE OF DEATH.

X 88

D43523

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Anna Meusel

(a) RESIDENCE. No.

Proffert Ave near Eastern Ave Park River

(Usual place of abode)

WARD

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 11 ds. How long in U. S., if of foreign birth? 29 yrs. 3 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 ~~Single, Married, Widowed~~ Married (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Herman Meusel

6 DATE OF BIRTH (month, day, and year) August 5 1890

7 AGE Years 29 Months 3 Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) County

10 NAME OF FATHER William H. Hillman

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Mary Long

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant C. M. Haggett (Address) North Point Road

15 MAY 27 1920

ROBERT A. LAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1920

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1920, to May 25, 1920, that I last saw her alive on May 25, 1920, and that death occurred, on the date stated above, at 2402 m.

The CAUSE OF DEATH* was as follows:

acute Hyperthyroidism

CONTRIBUTORY (Secondary) Myocardial infarction (duration) unknown yrs. 0 mos. 0 ds. (duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted at home if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) H. B. McElwain, M. D.

, 19 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Oak Lawn Cemetery May 27 1920

20 UNDERTAKER Mrs C. Kuller ADDRESS 2334 Jeffers

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43524

108 ✓ D43524

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hosp ST.: 10 WARD)

2-FULL NAME

(a) RESIDENCE. No. 1101 Asquith

(Usual place of abode)

ST. 10 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 6 1880

7 AGE Years 39 Months 10 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAY 27 1920

ROBERT H. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 19 20

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1920, to May 26, 1920, that I last saw him alive on May 26, 1920, and that death occurred, on the date stated above, at 9 P m. The CAUSE OF DEATH* was as follows:

General Peritonitis

CONTRIBUTORY (Secondary) Ruptured appendix (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 28 1920

Was there an autopsy? No

What test confirmed diagnosis? Laprotomy

(Signed) J. T. Darr, M. D.

, 19 (Address) St Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Catharine's May 29 1920

20 UNDERTAKER ADDRESS

H. C. Wiedefeld 914 Greenmount

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bkn.

D43525

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43525

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1005 Myrtle* ST. *17* WARD)

2-FULL NAME

William L. Barkman

(a) RESIDENCE

No. *1005 Myrtle* ST. *17* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

78 yrs. *11* mos. *19* ds.

How long in U. S., if of foreign birth?

78 yrs. *11* mos. *19* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

Singles

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 6, 1841

7 AGE

78 Years *11* Months *19* Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Joseph Barkman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Susan Reisinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

John Barkman
1005 Myrtle St

15

MAY 27 1920

ROBERT H. KRAUTER
Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 25, 1920*

17

I HEREBY CERTIFY, That I attended deceased from

May 14, 1920, to May 25, 1920,

that I last saw him alive on *May 24, 1920,*

and that death occurred, on the date stated above, at *5 P. M.*

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) *3* yrs. *—* mos. *—* ds.

CONTRIBUTORY (Secondary)

cardiac asthma

(duration) *5* yrs. *—* mos. *—* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *—*

Was there an autopsy? *no*

What test confirmed diagnosis? *urinalysis*

(Signed) *W. W. H. M. D.*

Physician (Address) *800 Harbor Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cem *May 27, 1920*

20 UNDERTAKER

Robert S. Little *531 E. Mount*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43526

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 S Ellwood Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Reinlein(Residence in Baltimore: No. 609 S Ellwood Ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male4-COLOR OR RACE, White5-FINGER, married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, June 21st, 1857

(Month)

(Day)

(Year)

7-AGE, 62 yrs., 11 mos., 5 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Mechanic(b) General nature of industry, business, or establishment in which employed (or employer), Shaw & Bros 319-BIRTHPLACE, (State or Country), Baltimore City10-NAME OF FATHER, John Reinlein11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER, Unknown13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pickens Reinlein(Address) 609 S Ellwood Ave15- MAY 27 1920 ROBERT E. ERAUTER
Filed 191 Basal Form 1-1-1914

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from March 6th 1917 to May 26th 1920,that I saw him alive on May 26th 1920,and that death occurred, on the date stated above, at 4⁴⁵ a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) 11 yrs., mos., ds.CONTRIBUTORY Hypertension
(Secondary)(Duration) 10 yrs., mos., ds.(Signed) J. H. Reinlein M. D.
May 27, 1920 (Address) 727 S. Ellwood Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.Where was disease contracted, if not at place of death? Former or usual residence Local Heat Co.19-PLACE OF BURIAL OR REMOVAL, Cath. Lawn Cem.DATE OF BURIAL, May 29, 192020-UNDERTAKER Lilly & Ziller ADDRESS 403 S. Volpe

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43527

CERTIFICATE OF DEATH.

10² D43527
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *821 S. First* ST.: *26* WARD)

2-FULL NAME

(Residence in Baltimore: No. *821 S. First* St.: *45 yrs., 11 mos., 28 ds.*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED, *Married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

May 26, 1874
(Month) (Day) (Year)

7-AGE,

*45 yrs., 11 mos., 28 ds.*If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Painter 050
*H. H. G.*9-BIRTHPLACE,
(State or Country),*Baltimore, Md.*

10-NAME OF FATHER,

*John Weidinger*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

Elizabeth Weidinger (Wife)
821 S. First St.

15-

Filed *MAY 27 1920* 101... *ROBERT P. FRANKS*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 24, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
May 8, 1920, to *May 24, 1920*,
that I saw him alive on *May 24, 1920*,
and that death occurred, on the date stated above, at *11:30 p. m.*
The CAUSE OF DEATH* was as follows:*Ulcer of the Stomach*
(Duration).....*2* yrs.*2* mos.*2* ds.CONTRIBUTORY.....
(Secondary)(Signed).....*Geo. Lockwood* M. D.
May 25, 1920 (Address).....*806 S. Third St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Cook Lawn Cem.

DATE OF BURIAL,

May 27, 1920

20-UNDERTAKER

Lily & Jailer

ADDRESS

403 S. Wolfe St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1006 EKS.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1135 Ething ST.: 17 WARD)

2-FULL NAME

(a) RESIDENCE. No. 1135 Ething

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE C 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of Mary Jones

6 DATE OF BIRTH (month, day, and year) April 26, 1888

7 AGE Years 32 Months 0 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Postal Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Handling mail

(c) Name of employer City Post Office

9 BIRTHPLACE (city or town) Richmond, Va. (State or country)

10 NAME OF FATHER James S. Jones

11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)

12 MAIDEN NAME OF MOTHER Sarah Howell

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant John E. Jones (Address) 1135 Ething St.

15 MAY 27 1920 ROBERT B. ERAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 19 20

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 19 20, to May 24, 19 20, that I last saw him alive on May 24, 19 20, and that death occurred, on the date stated above, at 11:15 P m. The CAUSE OF DEATH* was as follows:

Myocardial Regeneration (duration) yrs. 4 mos. 7 ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted City of Baltimore If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm. H. Wright M. D.

(Address) 1709 President St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Ambrose Cem. DATE OF BURIAL May 27 19 20

20 UNDERTAKER St. A. Holland ADDRESS 631 N. Mount

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43529

D43529

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *542 Oxford* ST.; *17* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Pauline P. Fitzhugh*(Residence in Baltimore: No. *542 Oxford* St.; *45* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *Col.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*6-DATE OF BIRTH, *June 29th*, 18*60*. (Month) (Day) (Year)7-AGE, *60* yrs., *1* mos., *4* ds. If LESS than 1 day, ...hrs. or...min.8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Domestic* (b) General nature of industry, business, or establishment in which employed (or employer), *070*9-BIRTHPLACE, (State or Country), *va*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Unknown*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary E. Cooper*(Address) *542 Oxford St.*

15-ROBERT H. KRAUTER

Filed MAY 27 1920

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 25*, 19*20*. (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 10* 19*20*, to *May 25* 19*20*, that I saw her alive on *May 24* 19*20*, and that death occurred, on the date stated above, at *8 A.* m.

The CAUSE OF DEATH* was as follows:

Cardiac Disease

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) *As Thrombosis*

(Duration) ... yrs. ... mos. ... ds.

(Signed) *C. R. Fowler* M. D.*May 26*, 19*20* (Address) *714 S. Spring St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *May 27, 1920*20-UNDERTAKER *John A. Holland* ADDRESS *1651 N. Highland*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43530

CERTIFICATE OF DEATH.

D43530

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1111 Battery Ave.* ST. *24* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1111 Battery Ave.* St. *24* yrs. *4* mos. *15* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

DATE OF BIRTH.

Mar 18 1872
(Month) (Day) (Year)

7-AGE,

67 yrs. *6* mos. *25* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Mechanic*

9-BIRTHPLACE, (State or Country),

Balto

10-NAME OF FATHER,

Mr. Hume

11-BIRTHPLACE OF FATHER (State or Country),

11 4

12-MAIDEN NAME OF MOTHER

May A. Bruden

13-BIRTHPLACE OF MOTHER (State or Country),

Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *May Strick*(Address) *1111 Battery Ave.*

15-

MAY 27 1920

ROBERT A. ERAUTER

Filed

191

Baltimore Health Department Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 26, 1920.
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *May 20* 1920, to *May 26* 1920, that I saw him alive on *May 25* 1920, and that death occurred, on the date stated above, at *10* m.

The CAUSE OF DEATH* was as follows:

Paralysis (Thrombosis)(Duration) *6* yrs. *6* mos. *6* ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis(Duration) *3* yrs. *3* mos. *3* ds.(Signed) *Dr. B. K. Hoff* M. D.*May 26*, 1920 (Address) *1202 E. 1st St.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *4* yrs. *4* mos. *4* ds. In the State *4* yrs. *4* mos. *4* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*New Calhoun & Co.**May 28, 1920*

20-UNDERTAKER

ADDRESS

*F. A. France & Son**7037 Kinner*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4001 Kathlamd Ave ST.; 15 WARD)

2-FULL NAME

(Residence in Baltimore: No. Same

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 63 yrs., 6 mos., 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH.

November 13, 1856
(Month) (Day) (Year)

7-AGE,

63 yrs., 6 mos., 12 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)at home9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

B. F. Hepler11-BIRTHPLACE OF FATHER
(State or Country),Pennsylvania

12-MAIDEN NAME OF MOTHER

Mary J. Snowden13-BIRTHPLACE OF MOTHER
(State or Country),Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. E. Hepler(Address) 4001 Kathlamd Ave

15-

Filed MAY 27 1920

ROBERT B. ERAUTER

BRIEF REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 25, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 25 1920, to May 25 1920, that I saw her alive on May 25 1920, and that death occurred, on the date stated above, at 1:00 p.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis(Duration) unknown yrs. mos. ds.CONTRIBUTORY
(Secondary)Edema of the lungs
Palmonary edema

(Duration) yrs. mos. ds.

(Signed) J. Perry Ross

M. D.

May 25, 1920 (Address) 13420 Beech Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Woodlawn CemMay 27, 1920

20-UNDERTAKER

ADDRESS

Chas. E. Branch807 Madison

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

ORE 138 ✓ D43532

CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. Feb yrs. mos. ds.)

St. Feb yrs. mos. ds.)

MEDICAL CERTIFICATE OF DEATH.

5-SINGLE, *Married*
MARRIED
WIDOWED
OR-DIVORCED,
(Write the word.)

OF BIRTH, January 9th, 1886.
(Month) (Day) (Year)

34 yrs. 4 mos. 19 ds.

... hrs. of ... min. ...

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Maryland

FATHER, Robert S. Casswell

OF FATHER
(State or Country), *Canada*

ME
RG
E
S. Lella R. Jackson

OF MOTHER
(State or Country), *Ecuador*

(Informant) Grace C. Greenfield

(Address) 8 Beechdale Road N.B.

Filed MAY 27 1920

ROBERT E. RAUTEE

Filed

Burial Permit **Revised**

16-DATE OF DEATH May 26, 1970
 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from
May 26 1920, to May 26 1920
that I saw her alive on May 26 1920
and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Gelucopsis luviana

..... (Duration).....yrs.....mos. 7...d

CONTRIBUTORY
(Secondary)

..... (Duration)..... yrs..... mos..... d.....

(Signed).....*W. H. D. Turner*.....M. 1

No. 26..., 191... (Address) 35413th St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSFERREES, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?.....

Former or usual residence 1416 Rossuch Ave

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL.

GREENMOUNT CEMETERY

MAY 28 1960

20-UNDERTAKER

Y. W. JENKINS & SONS CO

ADDRESS

MC CULLON & OFCHARD STS.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43533

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Womans Hospital*

REGISTERED No. C

CITY OF BALTIMORE: (No. *104* ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Betty Horper*(Residence in Baltimore: No. *1416 Gurnee Ln* St.;

yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

May 25, 1920, 1
(Month) (Day) (Year)

7-AGE,

1
yrs., mos., ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

9-BIRTHPLACE,

(State or Country),

Womans Hospital, Md.

10-NAME OF FATHER,

Thomas S. Horper

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Roberta Cassell

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Thomas S. Horper*(Address) *1416 Gurnee Ln*

15-

Filed

MAY 27 1920

ROBERT A. ERAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 26, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 26, 1920, to May 26, 1920*that I saw her alive on *May 26, 1920*and that death occurred, on the date stated above, at *2300* m.

The CAUSE OF DEATH* was as follows:

Fractured Skull

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

18-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*GREEN MOUNT CEMETERY CO.**MAY 28 1920*

20-UNDERTAKER

ADDRESS

JEANINE & SONS CO

MC CULLOH & OF CHARD STS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

4 am. D43531
139966

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Kapitany

D43531

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 7TH WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Kapitany

(a) RESIDENCE. NO. Birnsville W. Va. ST. unknown WARD. Birnsville W. Va.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 2 mos.

ds. How long in U. S., if of foreign birth

yrs. unknown mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of +

6 DATE OF BIRTH (month, day, and year) Aug 23 - 1872

7 AGE Years 47 Months 9 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work miner

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

10 NAME OF FATHER Mark Kapitany

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Julia Szabo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant J. H. H. Records (Address)

15 MAY 27 1920 ROBERT B. FRASER

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1920

17 I HEREBY CERTIFY, That I attended deceased from April 2nd, 1920, to May 25, 1920, that I last saw him alive on May 25, 1920, and that death occurred, on the date stated above, at 9-2 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Operation - Gastro-resection

(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Apr. 3, 1920

Was there an autopsy? yes

What test confirmed diagnosis? Pathological

(Signed) Mont R. Reed M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Cemetery

May 27 1920

20 UNDERTAKER

H. E. Hughes 17 S Broadway

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43535

D43535

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1421 Mosher* ST.; *16* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Rosie Shaffer*(Residence in Baltimore: No. *1421 Mosher* St.; *34* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *female*4-COLOR OR RACE, *Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *April 1888*

(Month)

(Day)

(Year)

7-AGE, *31*

yrs.

mos.

ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Domestic*
(b) General nature of industry, business, or establishment in which employed (or employer), *037*9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Ashbury Williams*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Blorhane Shaffer*(Address) *1421 Mosher St*

15-

MAY 27 1920

Filed

191

ROBERT R. KAUTER

Burial Permitted

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *5* — *24*, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 19* 1920, to *May 24* 1920, that I saw her alive on *May 24* 1920, and that death occurred, on the date stated above, at *2 p. m.*

The CAUSE OF DEATH* was as follows:

Endocarditis(Duration) *X* yrs. mos. ds.CONTRIBUTORY (Secondary) *Rheumatism*

(Duration) yrs. mos. ds.

(Signed) *J. Grant Smith* M. D.*May 24, 1920* (Address) *334 W. Baltimore St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *ent. at Town*
JAMES H. DENNISDATE OF BURIAL, *MAY 27 1920*

20-UNDERTAKER

ADDRESS

1303 PRESTMAN ST.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

D43536

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43536

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 Bruce ST.; 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ludmia Carroll

(a) RESIDENCE. No.

519 Bruce ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of James Carroll (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 7 1879

7 AGE 41 Years 3 Months 19 Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress &

(b) General nature of industry, business, or establishment in which employed (or employer)

Cook 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Beth Ind

10 NAME OF FATHER

Harry Perkins

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Beth Ind

12 MAIDEN NAME OF MOTHER

Mary Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Beth Ind

14

Informant (Address)

Frank Garrison
2235 Drive Hill An

15

MAY 27 1920

ROBERT A. LEATHER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Apr 29, 1920, to May 26, 1920, that I last saw her alive on May 25, 1920, and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Sputum test(Signed) William F. Fley M. D.526, 1220 (Address) 1928 Penna An

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mount Auburn MAY 28 1920

20 UNDERTAKER

JAMES H. DENNIS1303 PRESTMAN ST.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. 2.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Louis D. Gordon
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43537

D43537

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

174
22
St. WARD)
Louis D Gordon
531 Lee St

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

at 2 St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male
4-COLOR OR RACE. Negro
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married
6-DATE OF BIRTH. 1
7-AGE. 41 yrs. mos. ds.
8-OCCUPATION: (a) Trade, profession, or particular kind of work. Salesman
(b) General nature of industry, business, or establishment in which employed (or employer). 040

9-BIRTHPLACE. (State or Country). France
10-NAME OF FATHER. Kuhn
11-BIRTHPLACE OF FATHER. Prussia
12-MAIDEN NAME OF MOTHER. Kuhn
13-BIRTHPLACE OF MOTHER. Prussia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant). Lula Gordon
(Address). 531 Lee St

15- MAY 27 1920 ROBERT A. KRAUTER
Regist. Burial. Pl. 111. Cl. 111.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 27, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said investigation find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of Skull

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Signed) M. D.

(Address) 1010 E. 10th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

20-UNDERTAKER ADDRESS

Mrs. Geo. H. Hooper 406 W. Conway St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43538

CERTIFICATE OF DEATH.

79 D43538
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1641 N. Wolfe ST.; 8 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1641 N. Wolfe St.; Life yrs., 0 mos., 0 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Single

6-DATE OF BIRTH,

Jan. 27, 1857
(Month) (Day) (Year)

7-AGE,

63 yrs. 3 mos. 29 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer).....0699-BIRTHPLACE,
(State or Country),Ind.

10-NAME OF FATHER,

Sam J. Chasgreen11-BIRTHPLACE OF FATHER
(State or Country),Ind.

12-MAIDEN NAME OF MOTHER

Eliza Harrison13-BIRTHPLACE OF MOTHER
(State or Country),Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Emma Cantani.....(Address).....1641 N. Wolfe St......

15-

Robert P. Harrison,

MAY 27 1920

191

Burial Permit 069 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 26, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 1 1919, to May 26 1920,
that I saw he alive on May 25 1920,
and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Mitral Valvular Heart Disease(Duration).....1 yrs.....0 mos.....0 ds.CONTRIBUTORY.....
(Secondary)(Duration).....0 yrs.....0 mos.....0 ds.(Signed).....Dr. L. J. Fisher.....M. D.May 27 1920. (Address).....1823 N. East St......

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

May 28 1920

20-UNDERTAKER

William Cook

ADDRESS

502 E. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN should state
mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43539

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43539

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1519 E. Clement

ST. 24

WARD)

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

2-FULL NAME

Marjorieta Boudreau

(a) RESIDENCE. No.

1519 E. Clement

ST.

WARD.

Naonk Conn.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

3 mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed,
or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 7. 1913

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

6

6

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

none

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Naonk, Conn.

10 NAME OF FATHER

Angus Boudreau

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Canada

12 MAIDEN NAME OF MOTHER

Margaret Arsenault

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Canada

14

Informant
(Address)

Angus Boudreau
1519 E. Clement St.

MAY 27 1920

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-20-1920

17

I HEREBY CERTIFY, That I attended deceased from

May 8th, 1920, to May 25th, 1920

that I last saw her alive on May 25th, 1920

and that death occurred, on the date stated above, at 11:45 A. M.

The CAUSE OF DEATH* was as follows:

Brnako Pneumonia

(duration) yrs. mos. 16 ds.

CONTRIBUTORY
(Secondary)

Respiratory Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death? 1519 E. Clement?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. A. Shepard M. D.

(Address) 423 E. Ford

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy cross Cem. R. C.

May 28 1920

20 UNDERTAKER

M. J. Flynn

ADDRESS

1422 Light St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43540

D43540

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bay View Hospital

REGISTERED NO.

37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.:

WARD)

2-FULL NAME

Harry E. Mouns.

(a) RESIDENCE. NO.

1405 N. Central Ave

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Five

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Bessie Mouns.

6 DATE OF BIRTH (month, day, and year)

Dec. 12 / 1888

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

32.

5

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Boiler-Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Do.

12 MAIDEN NAME OF MOTHER

Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Do.

14

Informant (Address)

Bay View Hospital Baltimore, Md.

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 26, 1920

17

I HEREBY CERTIFY, That I attended deceased from

Dec. 17, 1920

May 26, 1920

that I last saw him alive on

May 26, 1920

and that death occurred, on the date stated above, at

10:15 a.m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Chronic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Furter Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death?

Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Mental & Serological

(Signed)

N. Harrison

M. D.

5/26/1920 Address)

Bay View Hospital

*State the Disease Causing Death, or in deaths from violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Carmel Cem.

May 28, 1920

20 UNDERTAKER

ADDRESS

M. A. Flynn

1422 Light

MAY 27 1920

Burial Permit Clerk

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43541

D43541

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2739 W. North Ave. St. 15 WARD)

REGISTERED NO. C

2-FULL NAME

Richard F. Kelly

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2739 W. North Ave St. 15 yrs. 40 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) married

6-DATE OF BIRTH.

Sept141899

7-AGE.

60812ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Locomotive Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) 030

9-BIRTHPLACE, (State or Country).

Baltimore Co. Md.

10-NAME OF FATHER.

Richard F. Kelly

11-BIRTHPLACE OF FATHER (State or Country).

unknown

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER (State or Country).

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lester J. Kelly

(Address)

2708 Winchester St.

15-

Robert P. HarrisonMAY 27 1920Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

5261920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 6 1920, to May 26 1920,that I saw him alive on May 25 1920,and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis(Duration) 1 yrs. 13 mos. 15 ds.

CONTRIBUTORY (Secondary)

Angina Pectoris

(Signed)

J. H. Kelly M. D.5/27/20 (Address) 2737 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 13 mos. 15 ds. In the State 1 yrs. 13 mos. 15 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Woodlawn Cemetery

DATE OF BURIAL.

MAY 29, 1920

20-UNDERTAKER

Geo. A. Gerbig 2001 W. Baltimore

ADDRESS

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43543

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43543

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1221 N. Broadway ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1221 N. Broadway ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Emma Hebb

6 DATE OF BIRTH (month, day, and year) Feb. 15, 1852

7 AGE

68 Years

Months 3

Days "

If LESS than 1 day, hrs. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Bay Pilot

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore City

10 NAME OF FATHER

Joseph Hebb, Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Mary Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore City

14

Informant (Address)

Henry Duncan Bayl.
1221 N. Broadway

15

Filed MAY 27 1920

Robert F. Harrison,

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1920

17

I HEREBY CERTIFY, That I attended deceased from May 25, 1920, to May 26, 1920, that I last saw him alive on May 25, 1920, and that death occurred, on the date stated above at 12:15 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

CONTRIBUTORY (Secondary) Angina Pectoris (duration) 2 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edgar P. Sandrock, M. D.

, 19 (Address) 1601 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery May 28 1920

20 UNDERTAKER

ADDRESS

Wm. C. Black 927 N. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2004 Westwood Ave., ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Senker (Junker)(a) RESIDENCE, No. 2004 Westwood Ave., ST., 15 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, Divorced (write the word) Widow,5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Senker,6 DATE OF BIRTH (month, day, and year) Sept. 14th 18847 AGE Years 85 Months 8 Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany,10 NAME OF FATHER Samuel Socks,11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany,12 MAIDEN NAME OF MOTHER Hilda Wolfram,13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany,14 Informant Mrs. B. Milhiser, (Address) 2004 Westwood Ave.,15 Filed May 27 1920 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25th 192017 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to May 25, 1920, that I last saw him alive on May 12, 1920, and that death occurred, on the date stated above, at 10-49 PM, The CAUSE OF DEATH* was as follows:Infirmity of Age (Senility)CONTRIBUTORY (Secondary) Garden Asthma (duration) 6 (2 1/2) ds. Indurated (duration) yrs. mos. ds.18 Where was disease contracted If not at place of death? ☒Did an operation precede death? ☒ Date ofWas there an autopsy? ☒

What test confirmed diagnosis?

(Signed) D. H. Howell M. D. , 19 (Address) 1929 W. Mt. Rd.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship, DATE OF BURIAL May 28th 192020 UNDERTAKER David L. Louden ADDRESS 118 W. Mt. Rd.

Burial Permit Clerk.

Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 27 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *116 Perry*)ST.: *22* WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. *116 Perry*)St.; *49* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Cauc

5-SINGLE,

*MARRIED**WIDOWED**OR DIVORCED**(Write the word)**Married*

6-DATE OF BIRTH,

July 5, 1870
(Month) (Day) (Year)

7-AGE,

49 yrs. 10 mos. 21 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....*porter*

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....*Johns*9-BIRTHPLACE,
(State or Country),*Baltimore*10-NAME OF
FATHER,*George S. Turner*11-BIRTHPLACE
OF FATHER
(State or Country),*Baltimore*12-MAIDEN NAME
OF MOTHER*Hannah Turner*13-BIRTHPLACE
OF MOTHER
(State or Country),*Calverton Co. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*Wife*(Address).....*300 N. L. Perry*

15-

MAY 28 1920

ROBERT E. KRAUTER

Filed.....

191...Baltimore...City...Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 26, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

April 26 1920, to *May 26 1920*,that I saw him alive on *April 25 1920*,and that death occurred, on the date stated above, at *4,500 P.*

The CAUSE OF DEATH* was as follows:

pleurisy & pneumonia

.....

.....

..... (Duration)..... yrs. mos. ds.

CONTRIBUTORY.....*thrombosis*(Signed).....*C. H. H. H. H.* M. D.*May 27 1920* (Address) *712 S. Perry St.*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

.....

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St. Paul's**May 28 1920*

20-UNDERTAKER

ADDRESS

John H. Toadwin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43546

D43546

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4804 Hadden Ave

REGISTERED NO. C

ST. 2nd WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 4804 Hadden Ave

St. 2nd yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE

MARRIED
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

Sept. 17, 1896
(Month) (Day) (Year)

7-AGE,

23 yrs. 8 mos. 14 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House Wife at Home

9-BIRTHPLACE,

(State or Country),

Balto City

10-NAME OF FATHER,

Matthais Harris

11-BIRTHPLACE OF FATHER (State or Country),

Balto City

12-MAIDEN NAME OF MOTHER,

Emma C Rigney

13-BIRTHPLACE OF MOTHER (State or Country),

Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Matthais Harris

(Address)

4804 Hadden Ave

15-

MAY 28 1920

ROBERT B KRAUTER

BALTIMORE CITY

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 26th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 20th 1920, to May 26th 1920,that I saw her alive on May 25th 1920,

and that death occurred, on the date stated above, at 8:00 m.

The CAUSE OF DEATH* was as follows:

The patient was in February 1919, followed by tubercular indications.

(Duration)....yrs....8....mos....ds.

CONTRIBUTORY
(Secondary)

(Duration)....yrs....mos....ds.

(Signed)

May 28, 1920 (Address) 1320 North Beech

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Truist Ridge May 28, 1920

20-UNDERTAKER

ADDRESS

A S Marshall 3539 Fall Rd

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43547

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43547

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1739 E. Balt St.) WARD

2-FULL NAME Mollie Gross

(Residence in Baltimore: No. 1739 E. Balt St.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

19 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown - 1 (Month) (Day) (Year)

7-AGE, 62 yrs. - mos. - ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Housewife (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Russia

10-NAME OF FATHER, Morris Kutner

11-BIRTHPLACE OF FATHER, (State or Country) Russia

12-MAIDEN NAME OF MOTHER, Esther Morris

13-BIRTHPLACE OF MOTHER, (State or Country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Balt St.

15- MAY 28 1920 ROBERT F. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 28, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) M. D. (Coroner) 5/28, 1920 (Address) 1010 E. Balt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, Rehrein Rosedale DATE OF BURIAL, May 28 1920

20-UNDERTAKER, Jack Lewis ADDRESS, 1411 E. Balt St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43548

CERTIFICATE OF DEATH.

D43548

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2430 Barclay ST.: 12 WARD)

2-FULL NAME Elizabeth Bessie Miller

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 2430 Barclay

ST. _____ WARD _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oliver Miller

6 DATE OF BIRTH (month, day, and year) July 6, 1876

7 AGE Years 43 Months 10 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Thos. B. Best

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Indiana Skeels

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Oliver Miller
(Address) 2430 Barclay St

15 Filed MAY 28 1920 ROBERT A. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan., 1920, to May 27, 1920, that I last saw him alive on May 27, 1920, and that death occurred, on the date stated above, at 5 109 m. The CAUSE OF DEATH* was as follows:

arterio-sclerosis - hypertens
(duration) 1 yrs. mos. ds.

CONTRIBUTORY apoplexy - cerebral
(Secondary) (duration) 1 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical & laboratory

(Signed) T. Frederick Lutz, M. D.

527, 1920 (Address) 2040 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Woodlawn Cemetery May 29 1920
20 UNDERTAKER ADDRESS

Joseph Super 1600 North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43549

CERTIFICATE OF DEATH.

64

D43549

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2605 Garrison Boulevard ST.; 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lewis Nicklas

(a) RESIDENCE. NO.

2605 Garrison Boulevard T.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

68 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Divorced5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec. 18, 1850

7 AGE

Years

Months

Days

If LESS than
1 day,.....hrs.
or.....min.6959

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired 10 years

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Germany

10 NAME OF FATHER

Andrew Nickolas

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Dorthea Paab

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant
(Address)Mary M. Nicklas
2605 Garrison Boulevard

15

MAY 28, 1920

ROBERT A. LAUTER

Registrar

Burial permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 17 1920

17

I HEREBY CERTIFY, That I attended deceased from
May 17, 1920, to May 27, 1920,
that I last saw him alive on May 26, 1920,
and that death occurred, on the date stated above, at 3:50 p.m.
The CAUSE OF DEATH* was as follows:Cerebral Hemiplegia(duration) yrs. mos. 10 ds.CONTRIBUTORY
(Secondary)(duration) yrs. mos. 1 ds.18 Where was disease contracted
if not at place of death?at place of death

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. D. Seldner, M. D.Address) 1501 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London ParkMay 29 1920

20 UNDERTAKER

H. Sander Son

ADDRESS

1700 Bluff

Information should be carefully supplied. All answers should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Dr. Seldner 1501 E. Eager St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43551

CERTIFICATE OF DEATH.

REGISTERED NO. 91-24-643551

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 E. Fort. an ST.: 24 WARD)

2-FULL NAME

Helen L. Tucker

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

104 E. Fort.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 9 mos. 18 ds. How long in U. S., if of foreign birth? 24 yrs. 9 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 8th 1895

7 AGE Years 24 Months 9 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Chas H. Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Alice Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Chas H. Tucker 104 E. Fort.

15 MAY 28 1920 ROBERT E. ERAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1920

17 I HEREBY CERTIFY, That I attended deceased from May 19 1919 to May 26 1920, that I last saw her alive on May 26 1920, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows: Epilepsy. Invalid epileptic idiot since injury to head and operation about 16 yrs ago

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) 16 yrs. 3 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 20 Date of

Was there an autopsy? 20

What test confirmed diagnosis? Physical

(Signed) M. D.

5/27, 1920 (Address) 1319 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cedar Hill Cem 5/29 1920

20 UNDERTAKER ADDRESS

J. F. M. Bully 124 E. Fort

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D43552

Emma A. Schaal 2410 Madison ave
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2410 Madison ST. 13 WARD)
2-FULL NAME Emma A. Schaal
(Residence in Baltimore: No. 2410 Madison St. (yrs., 5) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female
4-COLOR OR RACE, white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widow (Write the word.)
6-DATE OF BIRTH, Jan 16, 1844 (Month) (Day) (Year)
7-AGE, 76 yrs. 4 mos. 10 ds. If LESS than 1 day, ...hrs. or...min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, none
(b) General nature of industry, business, or establishment in which employed (or employer), none

9-BIRTHPLACE, (State or Country), Germany
10-NAME OF FATHER, Otto Yeager
11-BIRTHPLACE OF FATHER (State or Country), Germany
12-MAIDEN NAME OF MOTHER, Dont know
13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles W. P. Schaal
(Address) 2410 Madison ave

15- MAY 28 1920
Filed MAY 28 1920 ROBERT F. KRAUTER
Burial 1200 Reddick

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and made a report thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death (Inquest, autopsy or inquiry) on the date stated above.
The CAUSE OF DEATH* was as follows:
Calculated disease of heart
(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) ...yrs. ...mos. ...ds.

(Signed) J. H. ... M. D.
(Coroner.)

May 27, 1920 (Address) 2410 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Gudson Park DATE OF BURIAL, May 28, 1920

UNDERTAKER, Mr. Weber & Son 2503 Edmontha

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Ills.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43553

CERTIFICATE OF DEATH.

28

D43553

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Bey (Boeh)

(a) RESIDENCE. No. 227 S. Wolfe St.

ST. 2 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1894

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town)
(State or country)

Baltimore, Md.

10 NAME OF FATHER

Mike Boeh

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Teresa Miller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Denmark

14

Informant
(Address)

Hospital Records
M.T.H.

15

MAY 28 1920

ROBERT A. LAUTER
Registrar

Death Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1920

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 5, 1920, to May 27, 1920.

That I last saw him alive on May 27, 1920.

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY Tuberculous laryngitis
(Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputu.

(Signed) George R. Wilkerson, M. D.

5-27-20 Address Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cem.

May 27 1920

20 UNDERTAKER

ADDRESS

Lilly and Zuber

403 S. 10th St.

PHYSICIANS should state EXACTLY. Exact statement of OCCASION should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43554

D43554

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph's Hospital* ST. *V* WARD)

2-FULL NAME

Lavinia Hand

(a) RESIDENCE. NO. *1823 E. Lombard* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *20* yrs. mos. ds. How long in U. S., if of foreign birth? *14* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of *Sylvanus Hand* (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *unknown*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *50*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Middlebury Co, Va.* (State or country)

10 NAME OF FATHER *Basil Cornelli*

11 BIRTHPLACE OF FATHER (city or town) *Middlebury Va.* (State or country)

12 MAIDEN NAME OF MOTHER *Sarah Deibel*

13 BIRTHPLACE OF MOTHER (city or town) *Middlebury Va.* (State or country)

14 Informant *Sylvanus Hand* (Address) *1823 E. Lombard St*

15 *MAY 28 1920*

ROBERT A. REASTER

Bureau Permit 01671

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 25 1920*

17 I HEREBY CERTIFY, That I attended deceased from *May 16*, 19*20*, to *May 25*, 19*20*, that I last saw her *dead* on *May 25*, 19*20*, and that death occurred, on the date stated above, at *11:15 P.* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. ds. *1*

CONTRIBUTORY (Secondary)

Chronic Interstitial Nephritis

(duration) *2* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Physical signs*

(Signed) *P. B. Bromus* M. D.

5-26, 1920 Address *St Joseph's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cath Lane Cem.

DATE OF BURIAL

May 28 1920

20 UNDERTAKER

Lilly and Ziehl

ADDRESS

403 S. Mather

D43556

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43556

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *16th* WARD)

2-FULL NAME

George Evans

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

713 N. Bruce St.

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 26 - 1919

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Charles Evans

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Bessie Topping

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

14

Informant

(Address)

*Charles Evans**713 N. Bruce St.*

15

*MAY 28 1920**ROBERT E. KAUTER*

Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 26 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*May 12 1920, to May 26 1920,*that I last saw him alive on *May 26 1920,*and that death occurred, on the date stated above, at *7:45 a.m.*

The CAUSE OF DEATH* was as follows:

Pneumonia - Broncho(duration) yrs. mos. ds. *4*

CONTRIBUTORY (Secondary)

(duration) yrs. + mos. ds.

18 Where was disease contracted if not at place of death? *Patent Home*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Autopsy*

(Signed)

M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

MT Auburn MAY 28 1920

20 UNDERTAKER

JAMES H. DENNIS

ADDRESS

1303 PRESTMAN ST.

Physicians should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43557

CERTIFICATE OF DEATH.

43 D43557
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2311 East Lafayette Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth E. Niechardt(Residence in Baltimore: No. 2311 E. Lafayette ave St.; 54 yrs., 9 mos., 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, married
(Write the word.)6-DATE OF BIRTH, Aug 6th, 1865
(Month) (Day) (Year)7-AGE, 54 yrs., 9 mos., 9 ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 0319-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, William Prettyman11-BIRTHPLACE OF FATHER (State or Country), Ind.12-MAIDEN NAME OF MOTHER Elizabeth McCab13-BIRTHPLACE OF MOTHER (State or Country), Balt. Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Niechardt(Address) 2311 E. Lafayette ave15-MAY 28 1920 ROBERT B. ERAUTERFiled....., 191.....
Burial Permit Registered

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26th, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1912, to May 26th, 1920, that I saw her alive on May 26th 2 P.M., and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

General Carcinomatous, Liver
Right Parotid Gland & Stomach, Subacute
to removal of 2.4 years or earlier
(Duration).....yrs.....mos.....ds.CONTRIBUTORY Infection & Exhaustion
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) William Brinton M. D.May 27th, 1920 (Address) S.W. Cor. Calumet & Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1231 E. Calumet St.19-PLACE OF BURIAL OR REMOVAL, Mountain View DATE OF BURIAL, May 27th, 192020-UNDERTAKER Mrs. J. Canales ADDRESS 946 Clingworth St

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Raimers
HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D43558

CERTIFICATE OF DEATH.

28 D43558

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Patapsco ST. 23 WARD)

2-FULL NAME Anne E Raimers

(a) RESIDENCE. No. 1717 Patapsco ST. WARD.

(Usual place of abode)
Length of residence in city or town where death occurred 45 yrs. mos. ds.(If death occurred in a hospital or institution, give its NAME instead of street and number.)
(If nonresident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced
HUSBAND of Henry Raimers
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct - 1865

7 AGE Years 54 Months 7 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hauswirth

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Laurel Md.
(State or country)

10 NAME OF FATHER John Moran

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Ann

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)14 Informant Mrs. Myers
(Address) 1717 Patapsco

15 MAY 28 1920

ROBERT B. FAUTER
Registrar
Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1919, to May 27, 1920.

that I last saw her alive on May 26, 1920, at 8 A. M.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? Ex. Sputum

(Signed) J. H. Williams, M. D.

19 (Address) 1340 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Leder Hill

20 UNDERTAKER

Myr. Cook

DATE OF BURIAL

May 28/20

ADDRESS

802 E. North St.

Physicians should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43559

CERTIFICATE OF DEATH.

D43559

1-PLACE OF DEATH

Union Protestant Ref. Church

REGISTERED NO. C

CITY OF BALTIMORE: (No.

1614 Division

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Carson W. Harris

(Residence in Baltimore: No.

1415 E. I.

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH

Nov

30

1892

7-AGE

47

7

yrs., mos., ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Farmer

9-BIRTHPLACE, (State or Country),

Md

10-NAME OF FATHER

James S. Harris

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Margaret Green

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Walter Hughes

(Address)...

1614 Division St.

15-

MAY 28 1920

191

ROBERT E. KRAUTER

Burial Place

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May

27

1920

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from May 28 1920, to May 27 1920,

that I saw him alive on May 27 1920, and that death occurred, on the date stated above, at 8:30 PM.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

CONTRIBUTORY (Secondary)

Diabetes

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M.

(Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Still Pond Md.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Still Pond Md May 28, 1920

20-UNDERTAKER

ADDRESS

H. C. Wiedefeld 914 Green

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Physician should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43560

CERTIFICATE OF DEATH.

6-11-20
D43560

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 Griffin Court ST. 2 WARD)

2-FULL NAME

(a) RESIDENCE. No. 722 Griffin Court ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 6, 1919

7 AGE

Years 1

Months 4

Days 22

If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

10 NAME OF FATHER Anthony Bonova

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Christina Bonova

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14

Informant (Address) Anthony Bonova 722 Griffin Court

15

Filed MAY 28 1920

ROBERT H. LEATHER

Burial Permit 0147

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1920

17

I HEREBY CERTIFY, That I attended deceased from May 24, 1920, to May 27, 1920, that I last saw him alive on May 27, 1920, and that death occurred, on the date stated above, at 20 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Measles

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Persano, M. D.

May 27, 1920 (Address) 2314 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent Cemetery

DATE OF BURIAL May 28 1920

20 UNDERTAKER

Nicholas Wyffel Son

ADDRESS

378 N. ...

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43561

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 S East ave ST.: 1 WARD)

2-FULL NAME

(a) RESIDENCE. No. 700 S East ave ST.: 1 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Schmans

6 DATE OF BIRTH (month, day, and year) November 2 1862

7 AGE Years 57 Months 6 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John S. Fedda

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margareth Schmans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Schmans (Address) 700 S East ave

15 Filed MAY 28 1920 ROBERT E. EBAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1920

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1920, to May 26, 1920, that I last saw h. alive on May 25, 1920, and that death occurred, on the date stated above, at 2:30 p. m. The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 10/20

Was there an autopsy? No

What test confirmed diagnosis? Exploratory (Signed) M. J. Mc away M. D.

27. 1920 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Greenland Heart Cemetery May 1920

20 UNDERTAKER ADDRESS

Wendell D. Appleton 378 N. ...

Cause of death should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43562

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D43562

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Gough(a) RESIDENCE. No. 2633 N. Calvert St. ST. 12 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18467 AGE 74 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland
(State or country)10 NAME OF FATHER James Gough11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)12 MAIDEN NAME OF MOTHER Adelle Budes13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)14 Informant Hospital Records(Address) New City Hospital.15 MAY 28 1920 ROBERT A. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 192017 I HEREBY CERTIFY, That I attended deceased from January 2, 1920, to May 26, 1920,that I last saw him alive on May 26, 1920,and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency(duration) 1+ yrs. mos. ds.CONTRIBUTORY Chronic Diff. Nephritis
(Secondary)(duration) 1+ yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No special test(Signed) J. F. Pessel, M. D.May 27 1920 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park CemeteryMay 29 1920

20 UNDERTAKER

ADDRESS

Wendell D. Appel & Son37 S. E. Ave.

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43563

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

D43563

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1012 Vine* ST.: *18* WARD)2-FULL NAME *Walter Simpson*(Residence in Baltimore: No. *1012 Vine* St.: *37* yrs., *1* mos., *1* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE, *C*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Mar*6-DATE OF BIRTH, *May 24, 1883*

(Month)

(Day)

(Year)

7-AGE, *37* yrs., *1* mos., *1* ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Turner*(b) General nature of industry, business, or establishment in which employed (or employer) *040*9-BIRTHPLACE, (State or Country), *Balto*10-NAME OF FATHER, *James Simpson*11-BIRTHPLACE OF FATHER (State or Country), *MD*12-MAIDEN NAME OF MOTHER *Mary Morgan*13-BIRTHPLACE OF MOTHER (State or Country), *MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harriet T. Butler*(Address) *2553 Florida St*

15-MAY 28 1920

Filed....., 191.....

ROBERT F. EHAUTER

Burial Permit *Registered*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 25, 1920*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from *May 19, 1920*, to *May 25, 1920*,that I saw h alive on *May 25, 1920*,and that death occurred, on the date stated above, at *41P* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) *Pulm. Tuberculosis*

(Duration).....yrs.....mos.....ds.

(Signed) *J. H. Woodward* M. D.*May 25, 1920* (Address) *94 W. Fayette St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Laurel Lawn*DATE OF BURIAL, *April 28, 1920*20-UNDERTAKER *Brown & Land School St.*ADDRESS *114 W.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43564

CERTIFICATE OF DEATH.

28 ✓ D43564

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Hayes(a) RESIDENCE. No. 646 Raborg St.ST. 4 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

Colored

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Charles Hayes

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Maryland

10 NAME OF FATHER

Ed. Jackson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER Fannie ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant
(Address)

Hospital Records

M.T.H.

15

MAY 28 1920

ROBERT E. KRAUTER
Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26th 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 12th, 1920, to May 26th, 1920.that I last saw her alive on May 26th, 1920.and that death occurred, on the date stated above, at 11.45 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) yrs. 8 (?) mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed)

George R. Wilkins, M. D.

5-27-20

19

(Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Asbury
John W. HendersonADDRESS 1302E. M. M. M.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43565

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH
CITY OF BALTIMORE (No. 3617 Chestnut ST. 13 WARD)
FULL NAME *Moses E. Arnold*
(Residence in Baltimore: No. 3617 Chestnut St. 32 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*
4-COLOR OR RACE, *white*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *widowed*
6-DATE OF BIRTH, *July 8, 1864*
(Month) (Day) (Year)
7-AGE, *55* yrs. *10* mos. *18* ds.
If LESS than 1 day,hrs. or....min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Carpenter*
(b) General nature of industry, business, or establishment in which employed (or employer). *015*
9-BIRTHPLACE, (State or Country), *Ohio*
10-NAME OF FATHER, *Andrew Arnold*
11-BIRTHPLACE OF FATHER (State or Country), *Ohio*
12-MAIDEN NAME OF MOTHER, *Lavinia Paxton*
13-BIRTHPLACE OF MOTHER (State or Country), *Ohio*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Minnie Donovan*
(Address) *3617 Chestnut Ave.*

15-
MAY 28 1920
ROBERT E. KRAUTER
Burial Permit Registered

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 26, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by and from the death topsy or inquiry, on the day stated above.
The CAUSE OF DEATH* was as follows:

uraemia

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. H. Morrison* M. D.
(Coroner)

May 26 1920 (Address) *3632 Roland*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Mary's Hospital *5/29, 1920*

20-UNDERTAKER, ADDRESS

Donovan & son *3617 Chestnut Ave.*

Physician should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Hks.

Veditz
HEALTH DEPARTMENT—CITY OF BALTIMORE

D43566

CERTIFICATE OF DEATH.

120 ✓
D43566

1-PLACE OF DEATH

CITY OF BALTIMORE, No.

612 W Hamburg ST. 21

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Chas. Henry A Veditz

(a) RESIDENCE. NO.

612 W Hamburg ST. 21

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary E Veditz

6 DATE OF BIRTH (month, day, and year)

May 1864

7 AGE

55 6 19

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Chemist

(b) General nature of industry, business, or establishment in which employed (or employer)

Shapron & John

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

John Veditz

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Mary E Veditz

14

Informant (Address)

612 W Hamburg ST

15

MAY 28 1920

ROBERT A. LAUTER Registrar

Bacial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-27-1920

17

I HEREBY CERTIFY, That I attended deceased from

May 27, 1920

that I last saw him alive on May 27, 1920

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Uræmic Coma

CONTRIBUTORY (Secondary)

Ch Int neph.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John G. Schramm M. D.

, 19 (Address) 170 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oaklawn Cem

May 29 1920

20 UNDERTAKER

for Jacobsen Son 217 S. Dec

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43567

CERTIFICATE OF DEATH.

31 ✓ D43567
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 453 Orchard ST.; 17 WARD)

2-FULL NAME

(Residence in Baltimore: No. 453 Orchard St.; Life yrs. 0 mos. 0 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Caucasian5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Aug. 7, 1920
(Month) (Day) (Year)

7-AGE,

10 yrs. 9 mos. 17 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Child9-BIRTHPLACE,
(State or Country),Balt Md

PARENTS.

10-NAME OF FATHER,

Randolph M Daniel11-BIRTHPLACE OF FATHER
(State or Country),Va

12-MAIDEN NAME OF MOTHER

Lottie B Sneed13-BIRTHPLACE OF MOTHER
(State or Country),Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lottie B M Daniel(Address) 453 Orchard15
MAY 28 1920

ROBERT E. KAUTER

Filed..... 191.. BOBERT E. KAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 26, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 20 1920, to May 26 1920,that I saw her alive on May 25 1920,and that death occurred, on the date stated above, at 9:30 pm.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis
of recent development
probably latent and
progressing (Duration) for months ds.CONTRIBUTORY
(Secondary)(Duration) for months ds.(Signed) L. S. Smith, M. D.May 27 1920 (Address) 914 N. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 0 ds. In the 0 yrs. 0 mos. 0 ds. State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

20-UNDERTAKER

Wm. N. Johnson

DATE OF BURIAL,

May 29 1920

ADDRESS

1234 E. Ewing St.

N. B.—Every item of information should be carefully checked. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43568

D43568

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital* ST. *11* WARD)

2-FULL NAME

(Residence in Baltimore: No. *Middle River* St. *6* yrs. *6* mos. *6* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Female</i>	4-COLOR OR RACE. <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <i>None</i>
6-DATE OF BIRTH. <i>Oct 4</i> 1919 (Month) (Day) (Year)		
7-AGE. <i>5</i> yrs. <i>2</i> mos. <i>6</i> ds. If LESS than 1 day, ... hrs. or ... min.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		

9-BIRTHPLACE.
(State or Country), *Maryland*

PARENTS.	10-NAME OF FATHER. <i>James C. Green</i>
	11-BIRTHPLACE OF FATHER. (State or Country), <i>Maryland</i>
	12-MAIDEN NAME OF MOTHER. <i>Maggie Graham</i>
	13-BIRTHPLACE OF MOTHER. (State or Country), <i>Maryland</i>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James C. Green*
(Address) *Bengees*

15-Filed *Oct 31* 1919 *g. M. Harrison*
Registrar.

MAY 28 1920

ROBERT E. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *October 30* 1919.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Oct. 25* 1919, to *Oct. 30* 1919, that I saw her alive on *Oct. 30* 1919, and that death occurred, on the date stated above, at *6 p.m.* The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis
(Duration) *1* yrs. *6* mos. *6* ds.
CONTRIBUTORY (Secondary) *Diarrhoea*
(Duration) *6* yrs. *6* mos. *6* ds.
(Signed) *George W. Murgatroyd* M. D.
Oct 30 1919: (Address) *401 E. 25th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *6* yrs. *6* mos. *6* ds. In the State *6* yrs. *6* mos. *6* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Crematorium* DATE OF BURIAL, *Nov 1st* 1919.

20-UNDERTAKER, *Mrs. C. Miller* ADDRESS *2334 Jeff*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6-041 ✓ D43569

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

1033 N. Carey

St.:

16

WARD)

2-FULL NAME

Margaret Gambrell

(Residence in Baltimore: No.

1033 N. Carey St.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

single

6-DATE OF BIRTH.

May 28, 1918

7-AGE,

2 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

house

9-BIRTHPLACE, (State or Country),

Balto. Md.

10-NAME OF FATHER,

William H. Gambrell

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER,

Hella Jones

13-BIRTHPLACE OF MOTHER (State or Country),

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. W. H. Gambrell

(Address)

1033 N. Carey St.

MAY 28 1920

Filed

191

ROBERT R. KRAUTER

BRIDAL PERMIT OFFICE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 27, 1920

17-

I HEREDY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

quity find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Measles

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Broncho-pneumonia

(Duration) yrs. mos. ds.

(Signed)

J. D. Hennessy M. D.

May 28 1920 (Address) 2802 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Not Auburn

DATE OF BURIAL,

May 28 1920

20-UNDERTAKER

ADDRESS

Edward Ringgold 1463 N. Carey

10. D. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43570

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1305 Upton St. 17 WARD)

2-FULL NAME Nettie Frederick

(Residence in Baltimore: No. 1305 Upton St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 24 yrs. 3 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Black 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)

6-DATE OF BIRTH, Feb. 28, 1896 (Month) (Day) (Year)

7-AGE, 24 yrs. 2 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laundress (b) General nature of industry, business, or establishment in which employed (or employer) 04

9-BIRTHPLACE, (State or Country), Maryland

10-NAME OF FATHER, Charles Thornton

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Annie Kellum

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Mary Bell

(Address), 909 McCallough St.

15- ROBERT E. KLAUTER

MAY 28 1920 101- BURIAL PERMIT

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 28, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, au-

gury and that said deceased came to death (on the day stated above.)

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 3 yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary) organic heart disease

(Duration) 3 yrs. 3 mos. 3 ds.

(Signed) J. H. Hennessy M. D. (Coroner.)

May 28, 1920 (Address) 2502 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place in the of death 3 yrs. 3 mos. 3 ds. State 3 yrs. 3 mos. 3 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Mary's DATE OF BURIAL, May 28 1920

20-UNDERTAKER, John H. Owen ADDRESS 538 Bell

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43571

CERTIFICATE OF DEATH.

91 ✓ D43571

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 S Bethel

ST.: 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Charles Krueger*

(a) RESIDENCE. NO. 723 S Bethel

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>M</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Single</i>
-------------------	---------------------------------	---

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Jan 24 1920*

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		<i>4</i>	<i>3</i>	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At 0*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto Md*
(State or country)10 NAME OF FATHER *John Krueger*11 BIRTHPLACE OF FATHER (city or town) *Texas*
(State or country)12 MAIDEN NAME OF MOTHER *Elizabeth Kelly*13 BIRTHPLACE OF MOTHER (city or town) *Balto Md*
(State or country)14 Informant *John Krueger*
(Address) *723 S Bethel*

15 MAY 28 1920 ROBERT E. LEATHER

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/28* 19 *20*17 I HEREBY CERTIFY, That I attended deceased from *5/27*, 19 *20*, to *5/27*, 19 *20*that I last saw him alive on *5/27*, 19 *20*,and that death occurred, on the date stated above, at *12:25 A.M.* in.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia(duration) yrs. mos. *4* ds.CONTRIBUTORY *anemia & heart failure*
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Diagnosis by symptoms*(Signed) *Dr. H. A. Phillips*, M. D., 19 (Address) *16238 North Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Rosary Cmn *May 29- 1920*

20 UNDERTAKER ADDRESS

*James Giallorini 421 S Bond**llr*

Information should be carefully supplied. All should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43572

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D43572

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1306 Asquith ST.: 9 WARD)

2-FULL NAME Mary Ruppel

(a) RESIDENCE. No. 1306 Asquith ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of late George Ruppel (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 8 1850

7 AGE Years 69 Months 6 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) MD

10 NAME OF FATHER Justice Maurer

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Anna Meyer

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mr. Charles A. Ruppel (Address) 1306 Asquith

15 MAY 28 1920 ROBERT B. KRAUTER Registrar

Death Permit Stamp

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1920

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1920, to May 27, 1920, that I last saw her alive on May 27, 1920, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. J. Green M. D.

5-27-1920 (Address) 120 1/2 Asquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

May 31 1920

20 UNDERTAKER

Henry Wood

ADDRESS

1301 E. Egan

tion is very important. See instructions on back of certificates.

D43573

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43573

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Mercy Hospital*
CITY OF BALTIMORE (No. *2110 Allendale*St. *15* WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary A. Norman*(Residence in Baltimore: No. *2110 Allendale St*

St., yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

October 15th, 1869
(Month) (Day) (Year)

7-AGE,

50 yrs. *7* mos. *19* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work,...

(b) General nature of industry, business, or establishment in which employed (or employer)...

*at Home*9-BIRTHPLACE,
(State or Country),*New York*

10-NAME OF FATHER,

*Patrick Judge*11-BIRTHPLACE OF FATHER
(State or Country),*Ireland*

12-MAIDEN NAME OF MOTHER

*Catherine Riley*13-BIRTHPLACE OF MOTHER
(State or Country),*Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *W. H. Norman*(Address) *2110 Allendale*

15-

Robert P. Harrison,

MAY 28 1920

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 26, 1914
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an...
(Inquest, autopsy or inquiry)thereon and from the evidence obtained by said...
(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)*Dehydration & Anemia*

(Duration) ... yrs. ... mos. ... ds.

(Signed) *W. H. Riley* M. D.(Coroner.) *1639 Bay*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place *San Francisco* In the
of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence *2110 Allendale*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*New Cathedral**May 28 1914*

20-UNDERTAKER

ADDRESS *Orchard**Henry J. Jenkins & Son Co. 1000 Baltimore St.*

D4.3574

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

WIFE of

Elizabeth McCabe

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

MAY 28 1920

Robert F. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 13, 1920, to May 26, 1920,

that I last saw him alive on May 26, 1920,

and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Coronary Embolism

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Asphyxiation (Signed) Charles C. Franklin, M. D.

19 (Address) West Side Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19-H. P. Co.-1000 Bks.

D43575

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43575

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* ST.: *4* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *Chestertown, Md.* ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Negro

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Robert Doem

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

MAY 28 1920

Robert P. Harrison,

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5/28* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from *5/14*, 19*20*, to *5/28*, 19*20*, that I last saw him alive on *5/28*, 19*20*, and that death occurred, on the date stated above, at *8:30 a. m.* The CAUSE OF DEATH* was as follows:

Carcinoma of Breast. Operation 5/15/20

CONTRIBUTORY (Secondary)

Alcoholism, Fall & kick

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of *5/15/20*

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Wm. D. Ridge M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Chestertown - Md

May 29 1920

20 UNDERTAKER

ADDRESS

Stewart-Morven Co. (W. H. Morven) 108 W. North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43576

CERTIFICATE OF DEATH.

D43576

1-PLACE OF DEATH #

CITY OF BALTIMORE: (No. 2522 Eager Place ST. 7 WARD)2-FULL NAME Michelle Di Gennaro(a) RESIDENCE. No. 2522 Eager Place ST. 7 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

5/6/20.

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

MAY 28 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 27 19 20

17

I HEREBY CERTIFY, That I attended deceased from

May 10, 19 20, to May 27, 19 20that I last saw him alive on May 27, 19 20and that death occurred, on the date stated above, at 5:15 a.m.

The CAUSE OF DEATH* was as follows:

Double
Broncho-Pneumonia(duration) yrs. mos. 17 ds.CONTRIBUTORY
(Secondary)(duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Fred. R. Ryznski, M. D.

528 1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Baltimore Cemetery May 29 1920.
George J. Path 1735-Hanford Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE must be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43577

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43577

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Hopkins Hospital*
CITY OF BALTIMORE (No. *175-001*) ST. *6* WARD) REGISTERED NO. C
2-FULL NAME *Willie Wells*
(Residence in Baltimore: No. *2006 Jones Court*, St.: yrs., *8* mos. ds.)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Mr.</i>	4-COLOR OR RACE, <i>Black</i>	5-SINGLE, <i>Single</i> MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, <i>May 23, 1912</i> (Month) (Day) (Year)		
7-AGE, <i>8</i> yrs. <i>3</i> mos. <i>3</i> ds. If LESS than 1 day,hrs. or....min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work, <i>Barman</i> (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE, (State or Country), <i>Bass</i>		
PARENTS.	10-NAME OF FATHER, <i>Billy Wells</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>Maryland</i>	
	12-MAIDEN NAME OF MOTHER, <i>Sing Brown</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Maryland</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edith Brown*
(Address) *2006 Jones Court*

15-Signed *Robert P. Harrison*

Filed *MAY 28 1920* 101 Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 26, 1912*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Presented by physician
(Duration)yrs.mos.ds.

CONTRIBUTORY (Secondary) *Presented by physician*
(Signed) *W. J. Harrison* M. D. (Coroner.)
191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place In the
of deathyrs.mos.ds. Stateyrs.mos.ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Osbury Cemetery Mary 27, 1912

20-UNDERTAKER, ADDRESS

Milton Davis 413 N. Eden St

D43578

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43578

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 N. Caroline St. ST.; 5 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 426 N. Caroline St. St.; life yrs., — mos. — ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE,
MARRIED, Married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

April 10, 1872
(Month) (Day) (Year)

7-AGE,

48 yrs. 1 mos. 17 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....House work
D379-BIRTHPLACE,
(State or Country),Maryland

10-NAME OF FATHER,

Unknown11-BIRTHPLACE OF FATHER
(State or Country),Unknown

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or Country),Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benny Thomas(Address) 426 N. Caroline St.

15-

Robert P. HarrisonMAY 28 1920191
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 27, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 14, 1920 to May 27 1920that I saw him alive on May 27 1920and that death occurred, on the date stated above, at 10:30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus(Duration) 1 yrs. — mos. — ds.CONTRIBUTORY
(Secondary)(Duration) — yrs. — mos. — ds.(Signed) Robert P. Harrison M. D.5-28-1920 (Address) 120 1/2 Aisquith St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Asbury Cemetery May 28 1920

20-UNDERTAKER

ADDRESS

Milton Davis 413 N. Eden St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D43579

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43579

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *John Hopkins Hosp. 7* WARD)

2-FULL NAME

Harry Harmony

(a) RESIDENCE. No.

Rockland, Md. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2 yrs.* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*White*5 Single, Married, Widowed,
or Divorced (write the word)*Child*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Child*

6 DATE OF BIRTH (month, day, and year)

Oct 11-1919

7 AGE

Years

7

Months

15

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*None*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Maryland*

10 NAME OF FATHER

Friedrich Harmony

11 BIRTHPLACE OF FATHER (city or town)

Md.

(State or country)

12 MAIDEN NAME OF MOTHER

Bessie Harmony

13 BIRTHPLACE OF MOTHER (city or town)

Md.

(State or country)

14

Informant
(Address)*Hospital Record
J. 26-26*

15

Filed

, 19

Registrar

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 26 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*April 29, 1920, to May 26, 1920.*that I last saw him alive on *May 26, 1920*and that death occurred, on the date stated above, at *6:05 P. M.*

The CAUSE OF DEATH* was as follows:

Diarrhoea(duration) yrs. *1* mos. ds.CONTRIBUTORY
(Secondary)*Bronchitis acute*(duration) yrs. *1* mos. ds.18 Where was disease contracted
if not at place of death?*Pat. Stone*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

Chemical

(Signed)

W. H. H.

M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park Cem

DATE OF BURIAL

May 29 1920

20 UNDERTAKER

Joseph B. Cook

ADDRESS

1003 N. Baltimore St

Information should be carefully supplied. AGE should be stated EXACTLY. PREVIOUS AND PRESENT OCCUPATION should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43580

D43580

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 322 Whitridge Ave St.; 12 WARD)

2-FULL NAME

(Residence in Baltimore: No. 322 Whitridge Ave St.; 44 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Mar 3, 1876 (Month) (Day) (Year)

7-AGE, 44 yrs. 2 mos. 24 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Chief Clerk to Pres. W.M. Ry. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

10-NAME OF FATHER, Robert Porter

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Sallie Aldbaugh

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. P. Harrison

(Address) 2100 W. North Ave.

15- Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 27, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar. 27, 1920, to May 26, 1920, that I saw him alive on May 26, 1920, and that death occurred, on the date stated above, at 11:15 m.

The CAUSE OF DEATH* was as follows:

Lympho-sarcoma of the anterior mediastinum.

(Duration) 5 to 6 months

CONTRIBUTORY (Secondary)

(Duration) 5 yrs., 10 mos., 10 ds.

(Signed) C. H. Hoffman, M. D.

5/28, 1920 (Address) 2100 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Co.

DATE OF BURIAL,

May 29, 1920

20-UNDERTAKER

Joseph B. Cook

ADDRESS

11003 W. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 28 1920

N.B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43581

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D43581

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. *St. Mary's Woodbourne Ave* ST. *27* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John J. Byrne*

(Residence in Baltimore: No. *St. Mary's Woodbourne Ave* St. *30* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE *Married*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH *July* 1894
(Month) (Day) (Year)

7-AGE *75* yrs. *10* mos. ds. or min. ?
If LESS than 1 day, hrs.

8-OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
Gardener

9-BIRTHPLACE
(State or country)
Ireland

10-NAME OF FATHER *James Byrne*

11-BIRTHPLACE OF FATHER
(State or country)
Ireland

12-MAIDEN NAME OF MOTHER *Mary Byrne*

13-BIRTHPLACE OF MOTHER
(State or country)
Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Chris Byrne*

(Address) *Govanstown.*

15- Robert P. Harrison,

MAY 28 1920 191
Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May* 27, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased *Scrup*
on *May 27*, 1920, to, 191,

that I saw him alive on *May 27*, 1920,
and that death occurred, on the date stated above, at *8 a.* m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed), *C. A. Steynken* M. D.

May 28, 1920. [Address] *3949 Reemitt Ave*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St Mary's Gavan DATE OF BURIAL *May 29*, 1920

20-UNDERTAKER

John J. Talley ADDRESS *1318 Light St.*

D43582

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43582

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3326 Myrtle Place ST. 26 WARD)

2-FULL NAME

Katherine Murray

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 3326 Myrtle Pl. ST. 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

James B. Murray6 DATE OF BIRTH (month, day, and year) April 9 - 18967 AGE Years Months Days If LESS than 1 day, hrs. or min.
24 1 17 - - -

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

H. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Ind.10 NAME OF FATHER Thos. Bolleran11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Ind.12 MAIDEN NAME OF MOTHER May Gadden13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland14 Informant (Address) James Murray
3326 Myrtle Pl.

MAY 28 1920

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-26 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 23, 1920, to May 26, 1920.that I last saw him alive on May 26, 1920.and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (chronic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? Culture(Signed) J. W. B. B. B. M. D.6/28, 1920 (Address) 3307 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Patrick's Cemetery 5/29/192020 UNDERTAKER ADDRESS 3000J. G. Moran E. Baltimore

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43583

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43583

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 Gough ST. 2 WARD)

2-FULL NAME

Charles Reynolds

(a) RESIDENCE. No. 1808 Gough ST. 2 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Reynolds

6 DATE OF BIRTH (month, day, and year) Mar. 4 1855

7 AGE Years 65 Months 2 Days 20 If LESS than 1 day, hrs. 08 or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Letter

(b) General nature of industry, business, or establishment in which employed (or employer)

army

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Ind.

10 NAME OF FATHER

John Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Liverpool, Eng.

12 MAIDEN NAME OF MOTHER

May Hewson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Ruth Lewis
1808 Gough St

15

Informant (Address)

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-26 1920

17

I HEREBY CERTIFY, That I attended deceased from 49th St. 20, 18, to May 26, 1920, that I last saw him alive on May 25, 1920

and that death occurred, on the date stated above, at 11.45 p.m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Balto. City

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Des. Heller, M. D.

(Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

5/29 1920

20 UNDERTAKER

J. G. Moran

ADDRESS 3000

E. Bretch,

MAY 28 1920

D43584

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43584

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1163 Whiteroot ST.; 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1163 Whiteroot St.; 2 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE, <u>Col</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <u>Married</u>
-------------------------	--------------------------------	--

6-DATE OF BIRTH, 1910
(Month) (Day) (Year)7-AGE, 47 yrs., 0 mos., 0 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Maryland

PARENTS.	10-NAME OF FATHER, <u>Jack Young</u>
	11-BIRTHPLACE OF FATHER (State or Country), <u>Md.</u>
	12-MAIDEN NAME OF MOTHER <u>Unknown</u>
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Md.</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert P. Harrison
(Address) 1163 Whiteroot

15-

Robert P. Harrison,
1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26, 1910
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 25, 1910, to May 26, 1910, that I saw her alive on May 26, 1910, and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Subsiding Typhoid
(Duration) 2 yrs., 0 mos., 0 ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs., 0 mos., 0 ds.
(Signed) John G. Stuber M. D.
May 27, 1910 (Address) 206 N. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, 2 yrs., 0 mos., 0 ds. In the State, 2 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

McConnellville Church St. May 29, 1910.

20-UNDERTAKER, ADDRESS

Edward Ringgold, 1463 71/2 Carey St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 28 1920

D43585

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43585

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1401 N. Mount*ST: *15*

WARD)

REGISTERED No. C

2-FULL NAME

Agnes Brown

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1401 N. Mount*

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*Black*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

May (unknown) 1878
(Month) (Day) (Year)

7-AGE,

42 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laundress
041

9-BIRTHPLACE,

(State or Country),

Harford Co. Md.

10-NAME OF FATHER,

Charles Brown

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Elizabeth Robinson

13-BIRTHPLACE OF MOTHER

(State or Country),

Harford Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *C. A. Gossling*(Address) *1401 N. Mount St.*

15-

*Robert P. Harrison,**Burial Permit Clerk,*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 28, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest*
(Inquest, au-*opsy or inquiry.* and that said deceased came to death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. D. Hennessy* M. D.

(Coroner.)

May 28, 1920 (Address) *2802 Edw. P. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn

DATE OF BURIAL,

May 30, 1920

20-UNDERTAKER

Edward Figgold

ADDRESS

14637 1/2 Care

B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 28 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43586

CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 939 Forest ST.; 10 WARD)

2-FULL NAME

(Residence in Baltimore: No. 939 Forest St.; 67 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

April 14, 1853
(Month) (Day) (Year)

7-AGE.

67 yrs. 1 mos. 13 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....Housewife
0379-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. James G. Harrison(Address) 939 Forest St.

15-

MAY 29 1920

Robert P. Harrison,
Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 27, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 24 1920, to May 27 1920, that I saw her alive on May 26 1920, and that death occurred, on the date stated above, at 6 2 m.

The CAUSE OF DEATH* was as follows:

Acute Congestion of Lungs
Patient had suppressed pain
pericarditis for 30 yrs.
(Duration) yrs. mos. ds.CONTRIBUTORY Acute Bronchitis
(Secondary)(Signed) James M. Britton M. D.
May 28, 1920 (Address) 2009 Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Cathedral May 31, 1920

20-UNDERTAKER

ADDRESS

E. E. Wiedefeld 924 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43587

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43587

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *159*)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. *James H. Hahn Md*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *8* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE

Married
MARRIED
WIDOWED
OR DIVORCED
(Write the word.)

6-DATE OF BIRTH,

No one knows, 1
(Month) (Day) (Year)

7-AGE,

48 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Seaman*9-BIRTHPLACE,
(State or Country),*Poland*

10-NAME OF FATHER,

*No one knows*11-BIRTHPLACE OF FATHER
(State or Country),*1 2 1*

12-MAIDEN NAME OF MOTHER

*No one knows*13-BIRTHPLACE OF MOTHER
(State or Country),*1 2 1*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Charles Graham

(Address)

Turner Station Md

15-

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 27, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I am in charge of the remains described above, held in

thereon and from the evidence obtained by said

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

*Suicide by pistol**Shot*
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)*Shot*
(Duration) yrs. mos. ds.(Signed) *Wm. J. Gentry*
(Coroner)*529, 200* (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

May 29, 1920

20-UNDERTAKER

John M. Weber 1803 Bank St

ADDRESS

Filed *May 29, 1920* Robert P. Harrison, Registrar.

Burial Permit Clerk

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43588

HEALTH DEPARTMENT—CITY OF BALTIMORE D43588

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4 WARD)

2-FULL NAME

Marinda Hawkins

(a) RESIDENCE. No.

Morse Hill

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD.

Ann Arundel Co

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1911

7 AGE

9

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Wm Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

M. Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

University Data
Gen & Lombard

MAY 29 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-27 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 26, 1920, to May 27, 1920.that I last saw her alive on May 27, 1920.and that death occurred, on the date stated above, at 11:45 p.m.

The CAUSE OF DEATH* was as follows:

Tetanus Acute
(evidence of infection incision)(duration) 5 yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) 5 yrs. 5 mos. 5 ds.

18 Where was disease contracted

if not at place of death?

Morse Hill

Did an operation precede death?

no

Was there an autopsy?

yes

What test confirmed diagnosis?

(Signed) C. R. Schuman, M. D.Address University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Burnside Branch A.C.May 29 1920

20 UNDERTAKER

ADDRESS

John H. Deeny75 Light

D43589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *630 S. Monroe St.* ST.: *20* WARD)

2-FULL NAME

John E. Frambach

(a) RESIDENCE. No. *630 S. Monroe St.* ST.: *20* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *6*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)

10 NAME OF FATHER *Ed Frambach*

11 BIRTHPLACE OF FATHER (city or town) *Md* (State or country)

12 MAIDEN NAME OF MOTHER *Mary J. Schrock*

13 BIRTHPLACE OF MOTHER (city or town) *Md* (State or country)

14 Informant *John Frambach* (Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 28 1920*

17 I HEREBY CERTIFY, That I attended deceased from *May 27, 1920*, to *May 28, 1920*, that I last saw him alive on *May 27, 1920*, and that death occurred, on the date stated above, at *5 4* m. The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. ds.

CONTRIBUTORY *Foramen Ovale Lesion* (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Chas. H. Moore*, M. D.

May 27, 1920 (Address) *1-8 St. Broadway*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Cross Cem *5/29 1920*

20 UNDERTAKER ADDRESS

John J. Foley Sons *1318 Light*

MAY 29 1920 Robert P. Harrison,

Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43590

CERTIFICATE OF DEATH.

28 D43590
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 Whatecoat ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Pindle(a) RESIDENCE. NO. 1124 Whatecoat ST., 16 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 19, 19017 AGE Years 19 Months 3 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bath (State or country) Ind10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Pindle13 BIRTHPLACE OF MOTHER (city or town) West River (State or country) Ind14 Informant George P. Pendergast (Address) 1124 Whatecoat St.

15 Burial Permit Clerk

Registrar

Robert P. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 192017 I HEREBY CERTIFY, That I attended deceased from May 25, 1920, to May 25, 1920, that I last saw him alive on May 25, 1920, and that death occurred, on the date stated above, at 9:45 P m. The CAUSE OF DEATH* was as follows:Tuberculosis of Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No(Signed) William F. Fry M. D.6/6/20 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Zion CemeteryMay 29th 1920

20 UNDERTAKER

ADDRESS

Samuel H. Chase - son1400 North

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 29 1920

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D43591

PLACE OF DEATH

104✓
REGISTERED NO. D43591

CITY OF BALTIMORE (No.

St. Elizabeths Home.

ST. 9 WARD)

2-FULL NAME

Thomas Brooks

(Residence in Baltimore: No.

St. Elizabeths' Home

Str.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

black

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

July

14, 1919

(Month)

(Day)

(Year)

7-AGE

yrs. *10* mos. *15* ds.

If LESS than
1 day, hrs.
or min.?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

000

9 BIRTHPLACE
(State or country)

Balto.

10-NAME OF
FATHER

Benjamin Brooks

11 BIRTHPLACE
OF FATHER
(State or country)

Balto.

12 MAIDEN NAME
OF MOTHER

Lillian Driver

13 BIRTHPLACE
OF MOTHER
(State or country)

Phila Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Freddie White

(Address)

1638 W. 3rd St.

15.

Robert P. Harrison,

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

May

27

1919

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1

1919

to,

May 26

1919

that I saw him alive on

May 26

1919

and that death occurred, on the date stated above, at *8 A.* m.

The CAUSE OF DEATH* was as follows:

Rachitis

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)

Intestinal Intoxication

(Duration) yrs. mos. ds.

(Signed),

Frank J. Ayer

M. D.

May 2

1919

(Address)

2005 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Evergreen Cemetery

DATE OF BURIAL

May 29, 1919

20-UNDERTAKER

Theodore White

ADDRESS

1638 W. 3rd St.

MAY 29 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43592

D43592

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2434 Barclay ST.; 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Corbell(Residence in Baltimore: No. 2434 Barclay St.; 67 yrs., 4 mos., 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female4-COLOR OR RACE, white5-SINGLE, MARRIED, married,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, Jan 1, 1853.
(Month) (Day) (Year)7-AGE, 67 yrs., 4 mos., 13 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work Domestic(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer) Housework9-BIRTHPLACE,
(State or Country), Maryland10-NAME OF
FATHER, William Harry11-BIRTHPLACE
OF FATHER
(State or Country), Maryland12-MAIDEN NAME
OF MOTHER Susan Mabury13-BIRTHPLACE
OF MOTHER
(State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Corbell(Address) 2434 Barclay St.

15-

FUEd

Robert P. Harrison

191

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 28, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
May 22 1920, to May 28 1920,
that I saw him alive on May 27 1920,
and that death occurred, on the date stated above, at 11 a.m.
The CAUSE OF DEATH* was as follows:.....
.....
.....
.....
..... (Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary) Corbell Housework..... (Duration) yrs. mos. ds.
(Signed) G. P. Harrison M. D.
May - 28, 1920 (Address) 321 E. Cross St.*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS-
IENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence19-PLACE OF BURIAL OR REMOVAL, Berdeen MdDATE OF BURIAL, May 30, 192020-UNDERTAKER John O. MitchellADDRESS 201 N. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 29 1920

B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

D43593

CERTIFICATE OF DEATH

D43593

PLACE OF DEATH

CITY OF BALTIMORE (No.

414 Font Hill Ave

ST

WARD

FULL NAME

George H. Apple Jr

(Residence in Baltimore: No.

414 Font Hill Ave

Str. 67 yrs. 2 mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6. DATE OF BIRTH March 18, 1851 (Month) (Day) (Year)

7. AGE 69 yrs. 2 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION (a) Trade, profession, or particular kind of work Butcher (b) General nature of industry, business, or establishment in which employed (or employer) Beef Butcher

9. BIRTHPLACE (State or country) Germany

10. NAME OF FATHER Geo. Henry Apple

11. BIRTHPLACE OF FATHER (State or country) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Caroline Apple (Address) 414 Font Hill Ave

15.

Robert P. Harrison,

191

REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 28, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20, 1920, to May 28, 1920, that I saw him alive on May 27, 1920, and that death occurred, on the date stated above, at 11 A. M. The CAUSE OF DEATH* was as follows:

Atherosclerosis

Contributory (SECONDARY) Langmuir's (Duration) 2 yrs. mos. ds.

(Signed) J. H. Schmitt M. D. 5.28.20 (Address) 211 N. Lamar

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Olives Cemetery In 1920

20. UNDERTAKER ADDRESS

George Schmitt 2101 Park Ave

MAY 29 1920

D43595

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43595

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST. 4

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clinton Dungee(a) RESIDENCE. No. 653 W. Mulberry St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

Black

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1899

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)10 NAME OF FATHER Neal Dungee11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14

Informant
(Address)

Hospital Records

New City Hospital.

15

Filed

Robert P. Harris

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1920

17

I HEREBY CERTIFY, That I attended deceased from
May 3, 19 20, to May 27, 19 20,
that I last saw him alive on May 26, 19 20,
and that death occurred, on the date stated above, at 3:45 A. m.
The CAUSE OF DEATH* was as follows:*Empyema*

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank T. Barker, M. D.May 27, 1920 Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

West Point Va May 29 1920

20 UNDERTAKER

Daniel Earlson 946

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 29 1920

1043596

HEALTH DEPARTMENT—CITY OF BALTIMORE

1043596

CERTIFICATE OF DEATH.

42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 W. Hamburg ST.; 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ran Watkins

(a) RESIDENCE. No. 404 W. Hamburg ST., WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1/2* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

February

7 AGE

33

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balti.

Md.

10 NAME OF FATHER

Emmel Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Ran Treherne

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

14

Informant (Address)

Sarah E. Briller 503 W. Cray St.

15

File

MAY 30 1920

ROBERT H. FAUTER Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1920

17

I HEREBY CERTIFY, That I attended deceased from

Feb 19 1920 to May 27 1920

that I last saw him alive on May 27 1920

and that death occurred, on the date stated above, at 9-50 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

5-28, 1920 (Address) 120 1/2 Disquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Cem

5/30/20

20 UNDERTAKER

ADDRESS

J A Joadwin

146 W Hill

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43597

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Harvard A Kelly Hosp.
1416 Eastern Place

REGISTERED NO. C

D43597

CITY OF BALTIMORE: (No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Adele S. Prentice.

(Residence in Baltimore: No.

Harvard A Kelly Hosp.

St.; yrs., 1 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Spinal

6-DATE OF BIRTH,

June

15

1876

(Month)

(Day)

(Year)

7-AGE,

43

yrs.

11

mos.

14

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

at home

(b) General nature of industry, business, or establishment in which employed (or employer).

037

9-BIRTHPLACE, (State or Country),

Minneapolis Minn.

10-NAME OF FATHER,

S. R. Jensen

11-BIRTHPLACE OF FATHER (State or Country),

Denmark

12-MAIDEN NAME OF MOTHER

Selma S. Johnson

13-BIRTHPLACE OF MOTHER (State or Country),

Sweden

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

S. R. Jensen

(Address)

Great Falls Mont.

15-

MAY 30 1920

ROBERT E. KAUTER

Filed

191

Burial Place

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 29th

(Month)

(Day)

1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 15

1920, to

May 29

1920

that I saw her alive on

May 29

1920

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

General Sarcinoma

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

Myocardial failure

(Duration).....yrs.....mos.....ds.

(Signed) William H. Hill, Jr. M. D.

191... (Address) 1416 Eastern Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Great Falls Mont.

Former or usual residence Great Falls. Mont.

19-PLACE OF BURIAL OR REMOVAL,

Great Falls Mont.

DATE OF BURIAL,

May 30, 1920

20-UNDERTAKER

Chas. G. Black 742 W. North ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43598

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D43598
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hebrew Hospital 6 ST. 6 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1920 East Baltimore

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 14 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, 1870
(Month) (Day) (Year)

7-AGE, 50 yrs. mos. ds. If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Tailor
(b) General nature of industry, business, or establishment in which employed (or employer). 1880

9-BIRTHPLACE, (State or Country), Russia

10-NAME OF FATHER, Moses Cohen

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Israh Cohen

(Address) 1920 E. Balt.

MAY 30 1920 ROBERT H. KRAUTER

Filed 100 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I am in charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, au-

opsy or inquiry. And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. H. Krauter M. D.
(Coroner.)

191... (Address) 1880

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Hebrew Burial

DATE OF BURIAL, 5-30-20, 19..

20-UNDERTAKER, Jack Lewis

ADDRESS, 1401 E. Balt.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43599

CERTIFICATE OF DEATH.

D43599

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smith(a) RESIDENCE. No. 1931 Eutaw Place

ST.: _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

MaleBlackMarried

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofUnknown

6 DATE OF BIRTH (month, day, and year)

1864

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.56

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Altoona, Pa.
(State or country)

10 NAME OF FATHER

John Smith

11 BIRTHPLACE OF FATHER (city or town)

Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

Virginia

(State or country)

14

Informant Hospital Records(Address) New City Hospital

15

MAY 30 1920ROBERT E. KRAUTER

Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29, 1920

17

I HEREBY CERTIFY, That I attended deceased from
May 21, 1920, to May 29, 1920
that I last saw him alive on May 29, 1920
and that death occurred, on the date stated above, at 9:15 A.M.
The CAUSE OF DEATH* was as follows:Syphilis

(duration) ? yrs. mos. ds.

CONTRIBUTORY
(Secondary)General Paralysis
(duration) 1?? yrs. mos. ds.18 Where was disease contracted
if not at place of death??Did an operation precede death? No. Date ofWas there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) C. D. Spalding, M. D.May 29 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Chapin CemeteryJune 1 1920

20 UNDERTAKER

ADDRESS

Samuel T. Henshaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43600

CERTIFICATE OF DEATH.

REGISTERED NO. C

D43600

1-PLACE OF DEATH

OF BALTIMORE: (No. 376 Walnut ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 376 Walnut St.; 34 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

China

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)

6-DATE OF BIRTH.

May 27, 1885.
(Month) (Day) (Year)

7-AGE.

35

If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE, (State or Country),

Balto

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER (State or Country),

unknown

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER (State or Country),

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Collins

(Address) 541 Cornwell

15-

MAY 30 1920 191 ROBERT B. ELAUTE

Burial Register

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 27, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 27, 1920, to May, 1927,
that I saw him alive on May 27, 1920,
and that death occurred, on the date stated above, at 1040 P. M.

The CAUSE OF DEATH* was as follows:

Acute Indigestion
(Duration) 4 hrs yrs. mos. ds.

CONTRIBUTORY (Secondary)

Valvular disease of heart
(Duration) unknown yrs. mos. ds.
(Signed) William E. Butler M. D.
May 30 1920 (Address) 762 Doe pth.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Mt Auburn

DATE OF BURIAL.

May 30 1920

20-UNDERTAKER

Saul H. Hensley

ADDRESS

98 N. B. St.

Caution: See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43601

D43601

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *Quancock Va.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *2* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Black* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Scott Matthews* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *February*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *40*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Quancock Va.* (State or country)10 NAME OF FATHER *Isaac James*11 BIRTHPLACE OF FATHER (city or town) *Virginia* (State or country)12 MAIDEN NAME OF MOTHER *James*13 BIRTHPLACE OF MOTHER (city or town) *Va.* (State or country)14 Informant *Scott Matthews* (Address) *506 St Mary St*15 Filed *MAY 30 1920* *ROBERT E. KAUFER* RegistrarBurial *1234 St. John*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 28* 19*20*17 I HEREBY CERTIFY, That I attended deceased from *May 26*, 19*20*, to *May 28*, 19*20*, that I last saw her alive on *May 28*, 19*20*, and that death occurred, on the date stated above, at *9:10 A.M.* The CAUSE OF DEATH* was as follows:*Altered Lung over (following 9 pneumonia)*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Emphysema following pneumonia* (duration) yrs. mos. ds.18 Where was disease contracted *Home* If not at place of death?Did an operation precede death? *Yes* Date of *May 28 1920*Was there an autopsy? *No*What test confirmed diagnosis? *Symptoms Operation*(Signed) *John Stein* M. D. 5/29/20 (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Tasky Co Accomaco Co Va* DATE OF BURIAL *4/31*20 UNDERTAKER *Samuel Thomas* ADDRESS *5/8 W. B. Rd.*CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43602

CERTIFICATE OF DEATH.

79 ✓ D43602
REGISTERED NO. C

1-PLACE OF DEATH

Hebrew Hospital

CITY OF BALTIMORE: (No.

ST. 7

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Jacob J. Caplan

(Residence in Baltimore: No.

1635 Ashland Ave

St. 30 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Married

6-DATE OF BIRTH,

July

1

(Month)

(Day)

(Year)

7-AGE,

53

yrs.

— mos.

— ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Tailor

9-BIRTHPLACE, (State or Country),

Russia

10-NAME OF FATHER,

Harry Caplan

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Sam. Caplan

(Address),

1635 Ashland Ave

15-

Filed

MAY 30 1920

191

ROBERT A. ELAUTER

Special Permit Officer

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

29

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

5-11-1920, to 5-29-1920,

that I saw him alive on 5-29-1920,

and that death occurred, on the date stated above, at 12:30 AM.

The CAUSE OF DEATH* was as follows:

Subacute Bacterial
Endocarditis,
Hypertrophied & Dilated Heart
with Insufficiency.
(Duration)....yrs....mos....ds.CONTRIBUTORY
(Secondary)

(Duration)....yrs....mos....ds.

(Signed).....M. D.

May 29, 1920. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1635 Ashland Ave

19-PLACE OF BURIAL OR REMOVAL,

Balto. Hebrew

DATE OF BURIAL,

May 30, 1920

20-UNDERTAKER

J. Linnson

ADDRESS

1127 E Balto St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43603

CERTIFICATE OF DEATH.

D43603

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 Warden ST.; 10 WARD)2-FULL NAME Catherine Hardt(a) RESIDENCE. NO. 1010 Warden ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds.

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? 72 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofFrederick Hardt6 DATE OF BIRTH (month, day, and year) Oct. 16, 1837

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

82713

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)10 NAME OF FATHER Henry Blumenauer11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)12 MAIDEN NAME OF MOTHER Catherine Shunk13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14

Informant

(Address)

Margaret E. Walters
1010 Warden st

15

Filed

MAY 30 1920ROBERT E. WALTERS

Registrar

Burial permit 01000

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 27, 1920, to May 28, 1920,that I last saw him alive on May 28, 1920,and that death occurred, on the date stated above, at 10 A.m.

The CAUSE OF DEATH* was as follows:

Infermites of old age
and Varicella disease of
Heart(duration) 2 yrs. mos. ds.CONTRIBUTORY Quarantine
(Secondary)(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? 1(Signed) Thomas J. Simmons, M. D.19 (Address) 1010 Warden st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Frederick, Md.June 1 1920

20 UNDERTAKER

Girkler & GirklerADDRESS 1739Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Elizabeth Slicer McDonald

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43601

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *106 E. 23rd* ST. *12* WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.

WARD.

(If nonresident give city or town and State)

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Thomas McDonald

6 DATE OF BIRTH (month, day, and year)

Oct 4 - 1826

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*93**7*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Wm Slicer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

MD

12 MAIDEN NAME OF MOTHER

Margaret Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MD

14

Informant (Address)

Thomas McDonald
5-12 E. 23rd

15

MAY 30 1920

ROBERT A. LAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 28 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 20th

1920, to

May 28th

that I last saw him alive on

May 26th

and that death occurred, on the date stated above, at

375 m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

M. H. Fair, M. D.

19 (Address)

12 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Greenwood**May 31 1920*

20 UNDERTAKER

Wm C. C. C.

ADDRESS

12 E 25th St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43605

CERTIFICATE OF DEATH.

REGISTERED NO.

D43605

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2365 Modern ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Mucharowska(a) RESIDENCE. NO. 2365 Modern ST.; 1 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balti, Md
(State or country)10 NAME OF FATHER S. Stanislaw Mucharowski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia12 MAIDEN NAME OF MOTHER Mary Rodacka13 BIRTHPLACE OF MOTHER (city or town) City

(State or country)

14

Informant Mary Mucharowska
(Address) 236 S. Madison St.

15

MAY 30 1920

ROBERT E. LAUTER
Registrar
Baltimore City

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/29 1920

17

I HEREBY CERTIFY, That I attended deceased from

5/28, 1920, to 5/29, 1920,that I last saw him alive on 5/29, 1920,and that death occurred, on the date stated above, at 7:55 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia(duration) yrs. mos. 2 ds.CONTRIBUTORY Heart failure
(Secondary)(duration) yrs. mos. 1 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of 5/29Was there an autopsy? NoWhat test confirmed diagnosis? Sig. & symptoms(Signed) M. A. Prutsky, M. D., 19 (Address) 16238 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus Cem.May 31 1920

20 UNDERTAKER

ADDRESS

M. F. Sadowski405 S. Ann

TION is very important. See instructions on back of certificates.

D43606

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

138 D43606

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.: *21* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Helen Rahn(a) RESIDENCE. No. *830 Columbia Ave.* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *22* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Herbert Rahn

6 DATE OF BIRTH (month, day, and year)

1898

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*22**-**-*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

George Barker

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Washington D.C.

12 MAIDEN NAME OF MOTHER

Mamie C. Hodges

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

*Hospital Records.**University Hospital.*

15

MAY 30 1920

ROBERT R. KRAUTER

Burial Permit *0101*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 29 1920.*

17

I HEREBY CERTIFY, That I attended deceased from *May 28*, 19*20*, to *May 29*, 19*20*, that I last saw her alive on *May 29*, 19*20*, and that death occurred, on the date stated above, at *2.50 a.m.*

The CAUSE OF DEATH* was as follows:

Eclampsia(duration) — yrs. — mos. *2* ds.

CONTRIBUTORY (Secondary)

Myocardial Insufficiency

(duration) — yrs. — mos. ds.

18 Where was disease contracted?

If not at place of death? *830 Columbia Ave.*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical Findings*(Signed) *J. A. Buchner*, M. D., 19 (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery May 31 1920

20 UNDERTAKER

ADDRESS

Geo. Heinbockel 687 N. ...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43607 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1331 S Clinton ST. 26 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elvin J. Betch

(Residence in Baltimore: No. 1331 S Clinton St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, Single, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, May 20, 1919
(Month) (Day) (Year)

7-AGE, 1 yrs. - 6 mos. - 6 ds.
If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Banker
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore City

10-NAME OF FATHER, John Betch

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER, Anna E. Gismant

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Anna E. Betch

(Address), 1331 S. Clinton St.

15- MAY 30 1920

Filed MAY 30 1920 ROBERT B. LEATHER Registrar
Burial Permit Office

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 21st 1920, to May 28th 1920, that I saw him alive on May 28th 1920, and that death occurred, on the date stated above, at 130 P. m.
The CAUSE OF DEATH* was as follows:

Gastroenteritis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed), H. H. Schwartz M. D.
May 30, 1920 (Address), 1737 E. Egan St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cemetery
DATE OF BURIAL, May 31, 1920

20-UNDERTAKER, Zirkler + Zirkler
ADDRESS, 1737 E. Egan St.

Check or print in plain terms so that it may be properly transcribed. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43608

D43608

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *76*)ST. *9* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Cecelia Malloy
1324 Wilcox

(a) RESIDENCE. No.

ST. *9* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

2 yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 28th, 1918

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Thomas J. Malloy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mary C. Finck

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Mrs. Mary C. Malloy
1324 Wilcox St.

15

MAY 30 1920

ROBERT A. LEASTER
Registrar

Burial permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 28 1920

17

I HEREBY CERTIFY, That I attended deceased from *May 18*, 19*20*, to *May 28*, 19*20*.that I last saw her alive on *May 28*, 19*20*.and that death occurred, on the date stated above, at *1:00 P. M.*

The CAUSE OF DEATH* was as follows:

Bilateral otitis media

CONTRIBUTORY (Secondary)

(duration) yrs. *1* mos. *1* ds.*Meningitis*(duration) yrs. *10* mos. *10* ds.

18 Where was disease contracted if not at place of death?

*1324 Wilcox St.*Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*

What test confirmed diagnosis?

Spinal puncture

(Signed)

A. S. Wright M. D.

548, 1920 (Address)

Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral Cemu.**5/31/1920*

20 UNDERTAKER

ADDRESS

*John F. Howan & Son**404 Hollins St.*

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43609

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43609

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Warden ST.; 10 WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. 1014 Warden Street St.; Life mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE. <u>White</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <u>Married</u>
6-DATE OF BIRTH. <u>Feb</u> - <u>1901</u> (Month) (Day) (Year)		
7-AGE. <u>19</u> yrs. <u>3</u> mos. ds.		If LESS than 1 day, ...hrs. or...min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). <u>Housewife</u>		
9-BIRTHPLACE. (State or Country), <u>Balto Md</u>		
PARENTS.	10-NAME OF FATHER. <u>Unknown</u>	
	11-BIRTHPLACE OF FATHER. (State or Country), <u>Russia</u>	
	12-MAIDEN NAME OF MOTHER. <u>Unknown</u>	
	13-BIRTHPLACE OF MOTHER. (State or Country), <u>Russia</u>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L. Mc Geaney
(Address) 1014 Warden St.15-
Filed MAY 30 1920 ROBERT E. KAUTER
Burial 1875 CLAY

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 27, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from January 1920, to May 27 1920, that I saw her alive on May 27 1920, and that death occurred, on the date stated above, at 3:55 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
beginning very insidiously(Duration) 9 yrs. 9 mos. ds.CONTRIBUTORY Acute pulmonary Tuberculosis
(Secondary)(Duration) 4 yrs. 4 mos. ds.(Signed) Frank D. Smith M. D., 191... (Address) 1126 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ds. In the State ... yrs. ... mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Holy Redeemer DATE OF BURIAL May 31, 1920

20-UNDERTAKER

Harry Witzke ADDRESS 1531 W. ...

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43610

CERTIFICATE OF DEATH.

91 D43610

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Home of Aged*ST.: *20*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Carriline Smith

(a) RESIDENCE. No.

Home of Aged Franklin Fulton

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *5 1/2* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

N

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

—

6 DATE OF BIRTH (month, day, and year)

Feb. 13 - 1841

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*79**3**15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

—

(c) Name of employer

—

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Robert Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Mary Beaul

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

*Mrs. Ella Cuddy**Home of Aged*

15

Filed

*MAY 30 1920**ROBERT A. TRAISTER**BORIAL PARK*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May - 28 - 1920

17

I HEREBY CERTIFY, That I attended deceased from

*May - 25 - 1920 to May - 28 - 1920*that I last saw her alive on *May - 28 - 1920*and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH* was as follows:

Pneumonia and complications due to age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Heart Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

Clinical Ex. Wesley Cole(Signed) *Wesley Cole*, M. D.Address *7207 Garrison*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Landan Park**May 31 1920*

20 UNDERTAKER

Geoff Smith

ADDRESS

1000 R. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43611

CERTIFICATE OF DEATH.

104 D43611

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

3017 Presbury St

ST.: 15th

WARD)

2-FULL NAME

Nelly May Grabel

(a) RESIDENCE. NO.

3017 Presbury St

ST.: 15th

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 1

mos. 2⁴

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 2nd 1920

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

one

2⁴

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Bernard S. Grabel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Nelly May Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant

Bernard S. Grabel

(Address)

3017 Presbury St

15

MAY 30 1928

ROBERT B. KLAUTER

Registrar

Burial Permit 01277

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

15thST.: 15th

WARD)

ST.: 15th

WARD.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 30th

1920

17

I HEREBY CERTIFY, That I attended deceased from

May 25th

1920

to May 29th

1920

that I last saw her alive on

May 29th

1920

and that death occurred, on the date stated above, at 10 P M m.

The CAUSE OF DEATH* was as follows:

Acute Diphtheria

(duration)

yrs.

mos.

5 ds.

CONTRIBUTORY (Secondary)

Toxemia

(duration)

yrs.

mos.

2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

W. Garrison Marks, M. D.

19

(Address)

3018 Presbury St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Robert S. Little

May 31 1920

20 UNDERTAKER

Western Cem

ADDRESS

5311 Exm

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43612

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adeline Halloway(a) RESIDENCE. No. 18 S. Dallas St.

(Usual place of abode)

ST. 3 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yr. 1 mo. 1 ds.

ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofJoseph Halloway6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
40				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Virginia10 NAME OF FATHER Lud Epps11 BIRTHPLACE OF FATHER (city or town)
(State or country)Virginia12 MAIDEN NAME OF MOTHER Hannah ?13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Virginia14 Informant Hospital Records

(Address)

15

Filed

MAY 31 1920ROBERT A. KAUFER

Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 192017 I HEREBY CERTIFY, That I attended deceased from
April 27, 1920, to May 28, 1920,that I last saw her alive on May 27, 1920,and that death occurred, on the date stated above, at 3.40 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) yrs. 5 mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?UnknownDid an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed)

George R. Wilkin M. D.
5-28-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Dendron VaMay 30 1920

20 UNDERTAKER

ADDRESS 1725Mrs Rolt a Elliott as near

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D43613

1 PLACE OF DEATH *Cornwall Road Shepherd*
CITY OF BALTIMORE (No. *Mount Hollins St* ST. *19* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Mary Manning*
(Residence in Baltimore: No. *as above, Mount Hollins St* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) *Single*
6-DATE OF BIRTH *May 30, 1854*
(Month) (Day) (Year)

7-AGE *66* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work *Seamstress*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

Baltimore Md

10-NAME OF FATHER

John Manning

11-BIRTHPLACE OF FATHER (State or country)

Ireland

12-MAIDEN NAME OF MOTHER

Catherine Hogan

13-BIRTHPLACE OF MOTHER (State or country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Robert F. Leuter*

(Address) *Cornwall Road Shepherd*

15

MAY 31 1920

ROBERT F. LEUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *May 30th, 1920*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *April*, 191*9*, to, *May 29th*, 191*20*.
that I saw her alive on *May 29th*, 191*20*.
and that death occurred, on the date stated above, at *6 a. m.*
The CAUSE OF DEATH* was as follows:

Atherosclerosis
Chronic Myocarditis

(Duration) *1* yrs. *4* mos. *4* ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) *J. A. Chatard* M. D.
May 30th, 191*20*. (Address) *40 W. Biddle St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Charles Cemetery

DATE OF BURIAL

May 31, 1920

20-UNDERTAKER

John J. Foley Sons 1318 Light St

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43614

CERTIFICATE OF DEATH.

63

D43614

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1834 Fairmount Ave. ST. 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1834 W. Fairmount Ave. St. 19 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

F

4-COLOR OR RACE,

W.

5-SINGLE,
MARRIED,
WIDOWED,
OR SEPARATED.
(Write the word.)

Married

6-DATE OF BIRTH,

Feb.

16

1872

(Month)

(Day)

(Year)

7-AGE,

48

3

13

ds.

If LESS than 1 day,

...hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

Casper Shunk

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Caroline

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

D. C. Chenoweth

(Address)

1834 W. Fairmount Ave.

15-

MAY 31 1920

ROBERT E. KAUTER

Filed

191

BALTIMORE

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May

28

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 23 1920

to

May 28 1920

that I saw him alive on

May 28 1920

and that death occurred, on the date stated above, at 9:00 P. M.

The CAUSE OF DEATH* was as follows:

Multiple Sclerosis

(Duration)

2 yrs. 6 mos.

ds.

CONTRIBUTORY
(Secondary)

(Duration)

2 yrs. 6 mos.

ds.

(Signed)

Edward O. Keenan M. D.

May 31 1920

(Address)

74 W. Fullerton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Lorraine Cemetery

DATE OF BURIAL,

May 31, 1920

20-UNDERTAKER

Chesloweth Son Chesnut St.

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43615

CERTIFICATE OF DEATH.

X 28

D43615

1-PLACE OF DEATH

U.S. Marine Hosp. Balt.

REGISTERED NO.

CITY OF BALTIMORE: (No.

Baltimore Md.

ST. 12 WARD 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles Jones

(a) RESIDENCE

U.S. Marine Hosp. Balt.

ST. 12 WARD 14

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

16 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Seaman

086

(b) General nature of industry, business, or establishment in which employed (or employer)

Bay Hangers

(c) Name of employer

Balt. Ches. Fallaitic

9 BIRTHPLACE (city or town) (State or country)

North Carolina

10 NAME OF FATHER

Charles Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Hospital Records

15

MAY 31 1928

ROBERT R. RAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5/28 1920

17

I HEREBY CERTIFY, That I attended deceased from

3/22 1920, to 5/28 1920.

that I last saw him alive on 5/28 1920.

and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic pulmonary tuberculosis.

CONTRIBUTORY (Secondary)

(duration)

yrs.

4 mos.

ds.

(duration)

yrs.

1 mos.

ds.

18 Where was disease contracted if not at place of death?

Do not know

Did an operation precede death?

no

Date of

Was there an autopsy?

yes

What test confirmed diagnosis?

Autopsy 7/28

(Signed)

Chas. M. Vogel

M. D.

5/29 1920 (Address) U.S. Marine Hosp. Balt. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel Cem.

May 31 1920

20 UNDERTAKER

ADDRESS

Chenoweth Son Chestnut St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43616

CERTIFICATE OF DEATH.

REGISTERED NO.

D43616

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Md. General Hospital 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mr. Oscar Roelcke

(a) RESIDENCE. NO.

Woodlawn Md.

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Annie Roelcke

6 DATE OF BIRTH (month, day, and year)

Jan 14 - 1846

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

74

4

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Artist 001

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Oscar Roelcke

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Sant. R. R. R.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

William Roelcke 1420 N. Mulberry St.

15

MAY 31 1920

ROBERT E. BLAUER Registrar

Boris [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 28 1920

17

I HEREBY CERTIFY, That I attended deceased from May 13 1920, to May 28 1920,

that I last saw him alive on May 28 1920, and that death occurred, on the date stated above, at 630 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death? yes Date of May 21, 20

Was there an autopsy? no

What test confirmed diagnosis? exploratory laparotomy

(Signed) J. E. Wright M. D.

29. 1920 (Address) Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Cemetery

DATE OF BURIAL

May 31 1920

20 UNDERTAKER

James Dignam & Son 1000 [illegible] St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43617

CERTIFICATE OF DEATH.

39 D43617

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *20 N Madison* ST.: *11* WARD)2-FULL NAME *James Madison Thompson*(a) RESIDENCE, NO. *20 N Madison* ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *15* yrs.

mos.

ds.

How long in U. S., if of foreign birth? *life* yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*White*5 *Single, Married, Widowed,*
or Divorced (write the word)*Divorced*5a If *married*, *widowed*, or *divorced*
HUSBAND of
(or) WIFE of*Divorced*6 DATE OF BIRTH (month, day, and year) *Nov 7 1871*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*48**6**23*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Banker's*(b) General nature of industry,
business, or establishment in
which employed (or employer)*Broker*

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Massachusetts*

10 NAME OF FATHER

James M. Thompson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Connecticut

12 MAIDEN NAME OF MOTHER

Ann Redle

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

New York

14

Informant

(Address)

*Mrs. T. Still**20 N Madison St*

15

MAY 31 1920

ROBERT K. TRAUTER

Burial permit

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 30 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*May 19 1920*that I last saw him alive on *May 29 1920*and that death occurred, on the date stated above, at *8 a.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of floor mouth(duration) *2* yrs. mos. ds.CONTRIBUTORY *Cachexia*
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

*Baltimore*Did an operation precede death? *No* Date of *March 1919*Was there an autopsy? *No*What test confirmed diagnosis? *yes*(Signed) *Swanwick Buckler* M. D., 19 (Address) *800 Cathedral St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cem June 1 1920

20 UNDERTAKER

ADDRESS *Chesapeake**Henry Jenkins & Sons 1402 Collyer*

TION is very important. See instructions on back of certificates.

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43618

CERTIFICATE OF DEATH.

D43618

PLACE OF DEATH

CITY OF BALTIMORE (No. *2005. Oak.*)

ST. *12* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

(Residence in Baltimore: No. *2005 Oak St.*)

St.; yrs., (mos. *7*) ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *M*

4-COLOR OR RACE, *C.*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH, *Sept 17, 1919*

(Month)

(Day)

(Year)

7-AGE, *7 1/4*

yrs. mos. ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *m*

(b) General nature of industry, business, or establishment in which employed (or employer) *800*

9-BIRTHPLACE, (State or Country), *Balto Md*

10-NAME OF FATHER, *A. Finner*

11-BIRTHPLACE OF FATHER (State or Country), *Port Carbon Pa*

12-MAIDEN NAME OF MOTHER, *Cecile Shaden*

13-BIRTHPLACE OF MOTHER (State or Country), *Port Carbon Pa*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. Finner*

(Address) *2005 Oak St*

15 MAY 31 1920

ROBERT A. ERBSTER

Filed

191

BALTIMORE

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 30, 1920*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *John H. ...* M. D.

(Coroner) *3632 Roland*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. ...*

DATE OF BURIAL, *May 31, 1920*

20-UNDERTAKER, *James ...*

ADDRESS *1364 ...*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43619

CERTIFICATE OF DEATH.

REGISTERED No. C

D43619

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Church Hill & Benjamin* ST.; *6* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Pasadena, Md.* St.; yrs. mos. *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH

Feb. 2, 1865
(Month) (Day) (Year)

7-AGE

55 yrs. *3* mos. *26* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Boilermaker

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

James D. Boyd

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Mary Jane Stinchcomb

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Carrie L. Boyd

(Address)

Pasadena, Md.

15-

ROBERT E. KRAUTER

MAY 31 1920

BURIAL PERMIT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 28, 1920
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *May 13, 1920*, to *May 28, 1920*, that I saw him alive on *May 28, 1920*, and that death occurred, on the date stated above, at *5:10 p.m.*

The CAUSE OF DEATH* was as follows:

Chronic Cirrhosis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *W. H. Morgan* M. D.*May 28, 1920* (Address) *Church Hill & Benjamin*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *15* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Pasadena, Md.

Former or usual residence

Pasadena, Md.

19-PLACE OF BURIAL OR REMOVAL

Pasadena R.R. Co. Md.

DATE OF BURIAL

May 30, 1920

20-UNDERTAKER

H. Sandu & Sons

ADDRESS

1710 Fleet St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43620

104 D43620

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3607 Mt. Pleasant St., 26 WARD)

2-FULL NAME

William Leon Roberts

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

3607 Mt. Pleasant St., 26 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mich 8-1920

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

2

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore
Md.

10 NAME OF FATHER

Jesse F. Roberts

11 BIRTHPLACE OF FATHER (city or town)
(State or country)Bo Mont
Md.

12 MAIDEN NAME OF MOTHER

Anna Creal

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)London Co.
Va.

14

Informant
(Address)Anna Roberts,
3607 Mt. Pleasant St.

15

MAY 31 1920

ROBERT A. BRAUTER
Registrar

Boris permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 29 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 24 1920, to May 29 1920,

that I last saw him alive on May 28 1920,

and that death occurred, on the date stated above, at 12:01 P.M.

The CAUSE OF DEATH* was as follows:

Hes Colic

(duration) yrs. mos. 10 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wright S. S. S. M. D.

5/29/20 (Address)

3313 E. Baldr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn Cem.

DATE OF BURIAL

May 31 1920

20 UNDERTAKER

Lilly and Ziehl

ADDRESS

4031 N. ...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43621

CERTIFICATE OF DEATH.

28

D43621

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1042 W. Lexington ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Lousdorne

(a) RESIDENCE. No. 1042 W. Lexington ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., if of foreign birth? 1 yrs. 4 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE Col. 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/30/19

7 AGE Years 1 Months 4 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Henry Lousdorne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamaica B.W.I.

12 MAIDEN NAME OF MOTHER Rosa Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jamaica B.W.I.

14 Informant Henry Lousdorne (Address) 1042 W. Lexington

15 Filed MAY 31 1920 19 ROBERT A. LAUTER Registrar

Baptist Parish Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1920

17 I HEREBY CERTIFY, That I attended deceased from May 18th 1920, to May 29th 1920, that I last saw her alive on May 29th 1920, and that death occurred, on the date stated above, at 1030 P.m.

The CAUSE OF DEATH* was as follows:

Phthis Pulmonalis (Personal Knowledge) 11 yrs. ds.

CONTRIBUTORY Brouchitis. (History) 2 yrs. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical (Signed) J. Guy Bowley M. D. 5/30/1920 (Address) 908 S Sharp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER Brown and Ireland. Schmitt

ADDRESS 114 A

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43622

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1712 Bentalow* ST.; *15* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Katherine Goldstone(Residence in Baltimore: No. *1712 Bentalow St.* St.; *50* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female White

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Jan 3

(Month)

(Day)

(Year)

7-AGE,

76 yrs. *4* mos. *25* ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer) *4 037*

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Sharon Dehanger

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Sarah Dehanger

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jacob Goldstone*(Address) *1712 Bentalow St.*

15-

Filed *MAY 31 1920*

ROBERT E. EBAUTER

Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 29 - 1920
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *March 27 - 1920*, to *May 29 - 1920*, that I saw him alive on *May 29 - 1920*, and that death occurred, on the date stated above, at *3:10 P. m.*
The CAUSE OF DEATH* was as follows:*Mitral insufficiency*
Arteriosclerosis & Sclerosis
Several years
CONTRIBUTORY *Branchial asthma, Cardiac*
(Secondary) *hypertrophy & dilation*
(Duration) *2* yrs. *2* mos. ds.
(Signed) *Carlton M. Cook* M. D.
May 27, 1920. (Address) *1107 W. Janab St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Schuman Friends Home

DATE OF BURIAL,

5/31/20

20-UNDERTAKER

J. Ahrens Co 1611 Ward Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43623

CERTIFICATE OF DEATH.

92 D43623

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Waverly Street ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 216 S Broadway ST., 3 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Dawson6 DATE OF BIRTH (month, day, and year) Nov. 26th 18777 AGE Years 47 Months 6 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Detective BROOK(b) General nature of industry, business, or establishment in which employed (or employer) BROOK(c) Name of employer BROOK9 BIRTHPLACE (city or town) Eastern Shore (State or country) Maryland10 NAME OF FATHER Richard Dawson11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)12 MAIDEN NAME OF MOTHER Georgia Walter13 BIRTHPLACE OF MOTHER (city or town) Eastern Shore (State or country) Md.14 Informant Augusta Dawson (Address) 216 S. Broadway15 Filed MAY 31 1920

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 192017 I HEREBY CERTIFY, That I attended deceased from March 18, 1920, to May 29, 1920, that I last saw him alive on 5/29, 1920, and that death occurred, on the date stated above, at 4:00 a m. The CAUSE OF DEATH* was as follows: Septicemia(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 2 mos. ds.18 Where was disease contracted if not at place of death? HomeDid an operation precede death? Yes Date of 3/21/20Was there an autopsy? YesWhat test confirmed diagnosis? Blood culture (Signed) Oliver G. Foster, M. D.19 (Address) Ward. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery7/31 1920

20 UNDERTAKER

ADDRESS

Louis Keenan31 S. Bway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 4-9-19—H. P. Co.—1000 Bks.

D43624

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 Gilmor ST., 19 WARD)

2-FULL NAME Josephine Parker

(a) RESIDENCE. No. 523 Gilmor ST., WARD.

(Usual place of abode) Length of residence in city or town where death occurred 3 yrs. 4 mos. 18 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Dennis H. Parker (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 10, 1889 7 AGE Years 31 Months 4 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waper Hair Dresser. (b) General nature of industry, business, or establishment in which employed (or employer) 086 (c) Name of employer Self.

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Thomas Smallwood

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Jennie Smallwood

13 BIRTHPLACE OF MOTHER (city or town) Charles Co. Maryland (State or country)

14 Informant Dennis H. Parker (Address) 523 Gilmor St.

15 Filed MAY 31 1920 ROBERT E. KAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1920

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1920, to May 28, 1920, that I last saw her alive on May 28, 1920, and that death occurred, on the date stated above, at 2:40 P. m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (duration) 4 mos. 2 ds.

CONTRIBUTORY Sequel of Influenza, (Secondary) (duration) yrs. mos. 15 ds.

18 Where was disease contracted 523 Gilmor St. If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? TBC in Sputum.

(Signed) Wm. H. Wreghitt, M. D.

(Address) 1209 Presbiterian St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

MT Zion Church May 31 1920

20 UNDERTAKER ADDRESS 916

Daniel Easton Carm am

HEALTH DEPARTMENT--CITY OF BALTIMORE

D43625

CERTIFICATE OF DEATH

53 D43625

1 PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. 534 N. Payson ST. 20 WARD)2-FULL NAME Adam Wm. Papadopoulos

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 534 N. Payson St. 52 yrs. 1 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE Married
MARRIED
WIDOWED
OR DIVORCED
(Write the word)6-DATE OF BIRTH April 12th 1868
(Month) (Day) (Year)7-AGE 52 yrs. 1 mos. 16 ds. If LESS than 1 day, hrs. min.?8-OCCUPATION (a) Trade, profession or particular kind of work Baker 004
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE (State or country) Baltimore, Md.PARENTS
10-NAME OF FATHER George Vaglogos
11-BIRTHPLACE OF FATHER (State or country) Germany
12-MAIDEN NAME OF MOTHER Margaret Dietzel
13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles G. G. M.D.(Address) 1111 W. Linnell St.

15-

MAY 31 1920

ROBERT E. ERAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 28 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from March 28, 1920 to May 28, 1920,
that I saw him alive on May 27, 1920,
and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Pseudoleukemia,
(Hodgkins Disease)Short (Duration) 4 yrs. — mos. — ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Charles G. G. M. D.
May 28, 1920 [Address] 1111 W. Linnell St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL London Park Cemetery DATE OF BURIAL May 31, 192020-UNDERTAKER H. B. Neff ADDRESS 2236 Frederick AveExact statement of OCCURRENCE
State CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43626

CERTIFICATE OF DEATH.

30 D43626

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1575 Lemon ST. 19 WARD)2-FULL NAME Clifton Washington(a) RESIDENCE. No. 1575 Lemon ST. 19 WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 9mos. 1

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

Aug. 28-1914

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

9-1-

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Wm Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Lizzie Lyon

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Lizzie Lyon
1575 Lemon

15

MAY 31 1920

ROBERT E. ELAUTE

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 29 1920

17

I HEREBY CERTIFY, That I attended deceased from May 24 1920, to May 29 1920 that I last saw him alive on May 29 1920.and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

GP C. L. Lutz M. D.
May 29-1920 1373 St. North Bn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Auburn CemMay 31 1920

20 UNDERTAKER

ADDRESS

A. Jones207 S. Stricker

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43627

CERTIFICATE OF DEATH.

170 D43627
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 S. Stricker ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Emily Agnes Butterbaugh

(a) RESIDENCE

No. 121 S. Stricker

ST. _____ WARD _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 10 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofJoseph Finley Butterbaugh

6 DATE OF BIRTH (month, day, and year)

July 10, 1868

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.511020

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore, Md.

10 NAME OF FATHER

William R. Ward

11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

House

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

Maryland

14

Informant
(Address)J. S. Butterbaugh
121 S. Stricker St.

15

MAY 31 1920

ROBERT E. LAUTER

Registrar

Burial Permit 0122

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29, 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 27, 1920, to May 28, 1920,that I last saw her alive on May 28, 1920,and that death occurred, on the date stated above, at 9:45 A. M.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous Nephritis.Indefinite (duration) yrs. mos. ds.CONTRIBUTORY Indefinite
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? not knownDid an operation precede death? No Date of _____Was there an autopsy? no and pathologicalWhat test confirmed diagnosis? Urinary analysis(Signed) H. N. Arthur M. D., 19 (Address) 1476 W. Lammale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park.

DATE OF BURIAL

June 1st 1920

20 UNDERTAKER

A. Jones

ADDRESS

207 S. Stricker

CAUSE OF DEATH in plain terms, so that it may be properly classified. State is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43628

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Wyman Ave St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 207 Wyman Ave St. 26 yrs., 12 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH.

Aug 16, 1893
(Month) (Day) (Year)

7-AGE,

26 yrs., 9 mos., 12 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House duties

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Henry Long

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Annie Snyder

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joseph E. Metzger
207 Wyman Ave.
(Address)

15-

MAY 31 1920

ROBERT E. LAUTER

Burial Place

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 28, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from March 31 1920, to May 27 1920, that I saw her alive on May 27 1920, and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 6 yrs., 6 mos., 12 ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs., 1 mos., 12 ds.(Signed) J. F. Smith M. D.5/29, 1920. (Address) 19 Randolph St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs., 1 mos., 12 ds. In the State 1 yrs., 1 mos., 12 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

London Park

DATE OF BURIAL

May 31, 1920

20-UNDERTAKER

Henry Lutz

ADDRESS

1007 N. Bond

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43629

CERTIFICATE OF DEATH.

D43629

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2101 St Paul ST.: 12 WARD)REGISTERED NO.
(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)2-FULL NAME Martha Salina Cloud(a) RESIDENCE. No. 2101 St Paul ST. 12 WARD. Texarkana - Arkansas
(Usual place of abode) (If nonresident give city or town and State)Length of residence in city or town where death occurred 0 yrs. 0 mos. 8 ds. How long in U. S., if of foreign birth? 75 yrs. 0 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Widow</u>
5a If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Capt. Saml. O. Cloud</u>		
6 DATE OF BIRTH (month, day, and year) <u>May-6-1845</u>		
7 AGE <u>75</u>	Years <u>0</u>	Months <u>24</u>
		Days <u>24</u>
		If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of worknone(b) General nature of industry,
business, or establishment in
which employed (or employer)none

(c) Name of employer

none9 BIRTHPLACE (city or town)
(State or country)not known
Alabama10 NAME OF FATHER S. N. Cooper11 BIRTHPLACE OF FATHER (city or town)
(State or country)not known
Alabama12 MAIDEN NAME OF MOTHER Martha Gardner13 BIRTHPLACE OF MOTHER (city or town)
(State or country)not known
Alabama14 Informant Mrs. H. T. Holmes (daughter)
(Address) 2101 St Paul Street

MAY 31 1920

ROBERT B. ELLIOTT

Filed

19

Burial Permit Registry

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1920

17 I HEREBY CERTIFY, That I attended deceased from
May 26, 1920, to May 30, 1920,
that I last saw him alive on May 30, 1920,
and that death occurred, on the date stated above, at 6 p.m.
The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(duration) yrs. mos. 4 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?sameDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical exam.(Signed) M. A. Pearson, M. D.19 (Address) 2105 N. Charles St*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Texarkana, Arkansas June 1 1920

20 UNDERTAKER

ADDRESS

STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43630

CERTIFICATE OF DEATH.

120 D43630

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mount Hope Retreat*)ST. *28* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Anna Gallagher(a) RESIDENCE. NO. *Mount Hope Retreat*
(Usual place of abode)ST. *28* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *30* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *64* yrs. *0* mos. *0* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *May 16-1886*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
64 *0* *0* *0*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*(b) General nature of industry, business, or establishment in which employed (or employer) *Housework*

(c) Name of employer

9 BIRTHPLACE (city or town) *Phila Pa. Frankfurt*
(State or country)10 NAME OF FATHER *Michael Gallagher*11 BIRTHPLACE OF FATHER (city or town) *Ireland*
(State or country)12 MAIDEN NAME OF MOTHER *Winifred Fitzpatrick*13 BIRTHPLACE OF MOTHER (city or town) *Ireland*
(State or country)14 Informant *Records of Mt Hope Retreat*
(Address) *Mt Hope Retreat*15 *MAY 31 1920* *ROBERT E. TRAUTER*
Registrar
Burial Permit *0108*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 30* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from *Aug 1890* to *May 30th* 19*20*,
that I last saw her alive on *May 30th* 19*20*,
and that death occurred, on the date stated above, at *4-20 P.* m.
The CAUSE OF DEATH* was as follows:*Chr. Syphilis - 3 yrs - Complicated
by Gastro-Enteritis (2 mos)
abs*(duration) *3* yrs. *0* mos. *0* ds.CONTRIBUTORY *Chr. Mania*
(Secondary)(duration) *30* yrs. *0* mos. *0* ds.18 Where was disease contracted *Frankford Phila Pa*
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Frank J. Flannery* M. D.*May 30 1920* (Address) *Mt Hope Retreat - Balt Md*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Philadelphia Pa *June 1-1920*20 UNDERTAKER
STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)ADDRESS
*108 W. NORTH AVE.*CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instructions on back of certificates.

D43631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D43631

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Julius Hopkins Hospital* ST.: *10th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Aaron Goldsmith

(a) RESIDENCE. NO.

723 Eiser St Baltimore Md.

(Usual place of abode)

WARD.

Length of residence in city or town where death occurred

yrs. *Life* mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 15, 1920*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

Two weeks (14 days)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

C. Lined

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Harry Goldsmith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Sarah V.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

J. H. H. Records

15

MAY 31, 1920

ROBERT E. LAUTER

Registrar

Boris P. Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 30* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

May 29 19 *20*, to *May 29* 19 *20*,that I last saw him alive on *May 29* 19 *20*,and that death occurred, on the date stated above, at *11:00 P.* m.

The CAUSE OF DEATH* was as follows:

Prematurity(duration) yrs. mos. *14* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Harold L. Heggins* M. D.*5/30 1920* (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt. Carmel Cemetery**5-31-20*

20 UNDERTAKER

ADDRESS

*John A. Davis**1411 E. Baltimore*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43632

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

ROBERT E. KRAUTER

FROD

MAY 31 1920

BALTIMORE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 15 1920, to May 30 1920,
that I saw him live on May 3 1920,
and that death occurred, on the date stated above, at 10:07 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
Empyema
(Duration)..... yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

myocardial infarction
(Duration)..... yrs. 4 1/2 mos. ds.
(Signed)..... M. D.
1920 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. 4 mos. 15 ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 511 N. Kenwood Ave.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew Friendship 5-31, 1920.

20-UNDERTAKER

ADDRESS

Jack Lewis, 1411 E. Balto

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43633

D43633

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1230 E. Fort Ave ST.; 24 WARD)2-FULL NAME Elizabeth Pope(Residence in Baltimore: No. 1230 E. Fort Ave St.; 38 yrs., 19 mos., 24 da.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female4-COLOR OR RACE. White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married
(Write the word.)6-DATE OF BIRTH. July 10, 1856

(Month)

(Day)

(Year)

7-AGE. 63 yrs., 10 mos., 10 da.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country). Pennsylvania10-NAME OF FATHER, Unknown11-BIRTHPLACE OF FATHER (State or Country). Unknown12-MAIDEN NAME OF MOTHER Unknown13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dep. W. Kruer(Address) 1230 E. Fort Ave

15-

MAY 31 1920

ROBERT F. KRAUTER

BRIEF PUBLIC REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 30, 1920

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from May 15, 1920, to May 30, 1920, that I saw him alive on May 29, 1920, and that death occurred, on the date stated above, at 2011.
The CAUSE OF DEATH* was as follows:
Coronary thrombosis(Duration) 10 yrs., 10 mos., 10 da.CONTRIBUTORY (Secondary) Interference(Duration) 3 yrs., 3 mos., 3 da.(Signed) J. H. Kruer M. D.1731, 1021. (Address) 1021

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 10 yrs., 10 mos., 10 da. In the State 10 yrs., 10 mos., 10 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill CemeteryDATE OF BURIAL, June 1, 192020-UNDERTAKER, Robt J. TurnerADDRESS 1492 N. Broadway

important. See instructions on back of certificate.

14153
D43634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43634

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST.: *12* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Morgan

(a) RESIDENCE. NO.

1719 La Trappe St.

WARD.

Virginia

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. *unknown* mos. *3* ds.

How long in U. S., if of foreign birth?

yrs. *3* mos. *3* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>male</i>	4 COLOR OR RACE <i>Colored</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Single</i>
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5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Sept-9-1919*

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		<i>8</i>	<i>28</i>	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

800

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Virginia*

10 NAME OF FATHER

*James Morgan*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Virginia*

12 MAIDEN NAME OF MOTHER

*Elizabeth Palmer*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Virginia*

14

Informant
(Address)*J.H.H. Records*

15

Filed *JUN 1-1920*ROBERT E. FRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 30* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from *May 26*, 19 *20*, to *May 30*, 19 *20*, that I last saw him alive on *May 30*, 19 *20*, and that death occurred, on the date stated above, at *11 A.M.*

The CAUSE OF DEATH* was as follows:

Broncho pneumonia(duration) *—* yrs. *—* mos. *3* ds.CONTRIBUTORY
(Secondary)(duration) *—* yrs. *—* mos. *—* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *none*(Signed) *Harold L. Higgins, M.D.*, 19 (Address) *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Peterburg Va JUN 1-1920

20 UNDERTAKER

RC Gross 1405 McEldred

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43635

CERTIFICATE OF DEATH.

D43635

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1733 Clarkson

ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

John D. Linit

(Residence in Baltimore: No. 1733 Clarkson

St.; — yrs., 1 mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

April 30, 1920.
(Month) (Day) (Year)

7-AGE,

— yrs., 1 mos., — da.

If LESS than 1 day,

— hrs. or — min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

9-BIRTHPLACE,

(State or Country),

Balt. Md.

10-NAME OF FATHER,

J. D. Linit

11-BIRTHPLACE OF FATHER

(State or Country),

Balt. Md.

12-MAIDEN NAME OF MOTHER

Eliz. Pries

13-BIRTHPLACE OF MOTHER

(State or Country),

Balt. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. D. Linit

(Address) 1318 P. Charles st.

15-

Filed

JUN 1 - 1920

ROBERT E. FRAUTER

Burial Parsonage

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 31, 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 29, 1920, to May 31, 1920,

that I saw him alive on May 27, 1920,

and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Duration 36 hrs.

CONTRIBUTORY

(Secondary)

(Duration) — yrs., — mos., — da.

(Signed)

Robert E. Frauter M. D.

May 31, 1920 (Address) 1318 P. Charles st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — da. In the State — yrs., — mos., — da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Cedar Hill Cemetery

20-UNDERTAKEN

ADDRESS

Max J. L. L. L. L. 1428 S. Charles st.

important. See instructions on back of certificate.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43636

Lorelle F Eichelberger ✓
HEALTH DEPARTMENT—CITY OF BALTIMORE

D43636

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2nd General Hospital* ST. *11*)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Lorelle F. Eichelberger*

(a) RESIDENCE. NO. *868 Park Ave. The Bronx* ST. _____
(Usual place of abode)

WARD. _____
(If nonresident give city or town and State)

Length of residence in city or town where death occurred *30* yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>W.</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Widowed.</i>
5a If married, widowed, or divorced HUSBAND or (or) WIFE of <i>Byrd S. Eichelberger.</i>		
6 DATE OF BIRTH (month, day, and year) <i>Sept 7. 1866</i>		
7 AGE <i>54</i>	Years <i>7</i>	Months <i>24</i>
If LESS than 1 day, hrs. or min.		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

PARENTS	9 BIRTHPLACE (city or town) (State or country) <i>Richmond Co. Virginia</i>
	10 NAME OF FATHER <i>Henry H. Fauntleroy</i>
	11 BIRTHPLACE OF FATHER (city or town) (State or country) <i>Richmond Co. Va.</i>
	12 MAIDEN NAME OF MOTHER <i>Alberta Reid</i>
	13 BIRTHPLACE OF MOTHER (city or town) (State or country) <i>Norfolk Virginia</i>

14 Informant *Wm R. Fauntleroy*
(Address) *525 Calvert Building Balt.*

15 *JUN 1 - 1920* ROBERT E. ELAUTEA
Registrar
Burial Permit *01878*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 31* 19*20*
17 I HEREBY CERTIFY, That I attended deceased from *Jan 22*, 19*20*, to *May 31*, 19*20*, that I last saw her alive on *May 30*, 19*20*, and that death occurred, on the date stated above, at *7:00* a. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Breast

(duration) yrs. *10* mos. ds.
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*
Did an operation precede death? *No* Date of _____
Was there an autopsy? *No*
What test confirmed diagnosis?
(Signed) *Chas. G. Tucker*, M. D.
, 19 (Address) *2nd General Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL <i>Mt Olivet Cemetery, Frederick Md</i>	DATE OF BURIAL <i>Jun 2 1920</i>
20 UNDERTAKER <i>John B. Spence</i>	ADDRESS <i>1325 N. Pauline St.</i>

43637

GUY
HEALTH DEPARTMENT—CITY OF BALTIMORE

D43637

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Johns Hopkins Hospital*
CITY OF BALTIMORE: (No. *Broadway* ST.; *W* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Henry Guy*
(Residence in Baltimore: No. *Johns Hopkins Hospital* St.; yrs., mos. *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *single*
(Write the word.)6-DATE OF BIRTH, *Sept. 15, 1902*
(Month) (Day) (Year)7-AGE, *17 yrs. 8 mos. 16 ds.* If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *apprentice boiler maker*
(b) General nature of industry, business, or establishment in which employed (or employer), *Automotive Works*9-BIRTHPLACE,
(State or Country), *Va.*PARENTS.
10-NAME OF FATHER, *Joseph Guy*
11-BIRTHPLACE OF FATHER (State or Country), *Va.*
12-MAIDEN NAME OF MOTHER, *Kellam*
13-BIRTHPLACE OF MOTHER (State or Country), *Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Records of Johns Hopkins Hospital*

(Address)

15-

JUN 1 - 1920

ROBERT E. KRAUTER

Filed

191

BIRTH RECORD

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 31, 1920*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 21, 1920*, to *May 31, 1920*, that I saw him alive on *May 30, 1920*, and that death occurred, on the date stated above, at *3 a. m.* The CAUSE OF DEATH* was as follows:*Septicemic Encephalitis*.....(Duration).....yrs.....mos.....ds.
CONTRIBUTORY...*Pulmonary Edema*
(Secondary).....(Duration).....yrs.....mos.....ds.(Signed) *Hildegard Hermann M. D.*
May 31, 1920 (Address) *Johns Hopkins Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *10* ds. In the State yrs. mos. *10* ds.Where was disease contracted, if not at place of death? *Portsmouth, Va.*Former or usual residence *R. D. #2*

19-PLACE OF BURIAL OR REMOVAL,

Portsmouth Va.

DATE OF BURIAL,

May 31, 1920

20-UNDERTAKER

Joe B. Cook

ADDRESS

1034 Balto st.

10.43638

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 430 E 21 St

ST. 12 WARD)

2-FULL NAME

Mazie Packwood

(Residence in Baltimore: No. 430 E 21 St

REGISTERED NO. C

D43638

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE

MARRIED
WIDOWED
OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH.

Mar 4, 1891
(Month) (Day) (Year)

7-AGE.

29 yrs. 2 mos. 25 ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

At Home
0379-BIRTHPLACE,
(State or Country),

Balto City

10-NAME OF FATHER,

Thomas B. Dittell

11-BIRTHPLACE OF FATHER
(State or Country),

Howard Co

12-MAIDEN NAME OF MOTHER

Laura Caspary

13-BIRTHPLACE OF MOTHER
(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Ralph H. Packwood

(Address)

430 E 21 St

15-

Filed JUN 1 - 1920

ROBERT E. KRAUTER

Burial Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 29, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
May 21, 1920, to May 29, 1920,
that I saw her alive on May 20, 1920,
and that death occurred, on the date stated above, at 9-30 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Duration)....yrs....mos....ds.CONTRIBUTORY
(Secondary)(Signed) H. L. Fair M. D.
May 31, 1920 (Address) 12 E 25-4 St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. Is the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Spring Ridge

Jun 1, 1920

20-UNDERTAKER

ADDRESS

H. S. Marshall 3539 Fall Rd

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43640

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155

D43640

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Joseph Hospital*)

2-FULL NAME

(Residence in Baltimore: No. *Carney Heights*)

ST.: *9*

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Harford Rd St.; yrs., *2* / mos. *4* / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) *Single*

6-DATE OF BIRTH,

Jan (Month) *26* (Day) *1899* (Year)

7-AGE,

21 yrs. *4* mos. *9* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Balto

10-NAME OF FATHER,

Agustavus Harold

11-BIRTHPLACE OF FATHER (State or Country),

Balto

12-MAIDEN NAME OF MOTHER

Theresa C. Wiley

13-BIRTHPLACE OF MOTHER (State or Country),

Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Agustavus Harold*

(Address) *923 Ramsey St*

15-

JUN 1 - 1920

ROBERT E. KRAUTER

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May *30*, *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by bullet

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *John J. [Signature]* D. (Coroner.)

4-21, 19*20* (Address) *4 E. [Signature]*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Baltimore City

DATE OF BURIAL,

June 2, 19*20*

20-UNDERTAKER

John [Signature] 1200 N. Lombard St

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43641

CERTIFICATE OF DEATH.

15 D43641

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 S. Charles ST.: 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Matilda Steiner

(a) RESIDENCE. No.

1022 S. Charles

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Steiner6 DATE OF BIRTH (month, day, and year) Aug 21, 18327 AGE Years 87 Months 9 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Coronell, Pa. (State or country)

10 NAME OF FATHER

Jacob Fritz

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant (Address)

Mr. Mowbray
1022 S. Charles St.

15

Filed

JUN 1 - 1920ROBERT A. ELLIOTT
Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/31 1920

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1920, to May 31, 1920, that I last saw her alive on May 30, 1920, and that death occurred, on the date stated above, at 8 A.M. The CAUSE OF DEATH* was as follows:Infirmities of age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. Edgar Smith M. D.7/31/20 (Address) 910 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL

DATE OF BURIAL

Londan ParkJune 2 1920

20 UNDERTAKER

ADDRESS

William Cook5025 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43642

CERTIFICATE OF DEATH.

120 D43642

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Philip Hiss Hess

(a) RESIDENCE. NO.

St. Mary's Orphan Asylum

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Mary H. Hess

6 DATE OF BIRTH (month, day, and year)

Aug 8 - 1848

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Don't know

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Don't know

14

Informant
(Address)

Mary H. Hess

2544 Greenmount

15

JUNI - 1920

ROBERT A. LAUTER

Registrar
Burial Permit 0100

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 31, 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 11, 1920, to May 31, 20

that I last saw him dead May 31, 20

and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY Chronic Interstitial

Nephritis (duration) 10 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) J. B. Bronushas, M. D.

5-31-20 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lorraine

June 2 - 1920

20 UNDERTAKER

William Cook

ADDRESS

5525 N. Malt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43643

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3456 Park Heights av

ST. 15 WARD)

2. FULL NAME

John Joseph Honeman

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 3456 Park Heights av

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year) Sept 5-1916

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 3 8 25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md - (State or country)

10 NAME OF FATHER Henry L. Honeman

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md -

12 MAIDEN NAME OF MOTHER Maud E. Wilson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md -

14 Informant Mrs H. J. Honeman (Address) 436 E. North av.

JUN 1 - 1920

ROBERT R. ERROTTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 23 1920, to May 30 1920,

that I last saw him alive on May 30 1920,

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Broncho. Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John S. Farby M. D.

930, 1920 (Address) 3522 Greenmount av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lorraine

June 1 1920

20 UNDERTAKER

William Cook

ADDRESS

502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43644 155 D43644

CERTIFICATE OF DEATH.

PLACE OF DEATH CITY OF BALTIMORE

REGISTERED NO. C

WARD

FULL NAME Frank Herbst

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1601 Emswiler St., 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

1-SEX Male

2-COLOR OR RACE white

3-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

4-DATE OF BIRTH, 20 or 11 Know 1 (Month) (Day) (Year)

5-AGE, 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.

6-OCCUPATION: (a) Trade, profession, or particular kind of work. Watchmaker. (b) General nature of industry, business, or establishment in which employed (or employer). 039

7-BIRTHPLACE, (State or Country), Connecticut.

8-PARENTS.

9-NAME OF FATHER, Josephine Herbst

10-BIRTHPLACE OF FATHER (State or Country), Germany.

11-MAIDEN NAME OF MOTHER, Rose Uhl

12-BIRTHPLACE OF MOTHER (State or Country), Conn.

13-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur L. Benbow

(Address) 1345 N. Emswiler St.

14-ROBERT E. KRAUTER

15-JUN 1 1920

16-REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11/30, 1920 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held in (Inquest, autopsy or inquiry.)

18-And that said deceased came to death (Inquest, autopsy or inquiry.)

19-CAUSE OF DEATH* was as follows: Smad by Murate Acid.

20-CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

21-(Signed) (Coroner) M. D. 5.30, 1920 (Address) 7 E. Emswiler

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

22-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place In the of death yrs. mos. ds. State yrs. mos. ds.

23-Where was disease contracted, if not at place of death?.....

24-Former or usual residence.....

25-PLACE OF BURIAL OR REMOVAL, Woodlawn

26-DATE OF BURIAL, June 20 1920

27-ADDRESS 502 E. North Ave

28-UNDERTAKER William Cook

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43645

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 623 S. 12th ST.)

WARD (No. 26)

2-FULL NAME

William Rieley Lathroum

(a) RESIDENCE. NO.

523 S. 12th ST.

ST.

WARD.

St. Mary's Ind.

(Usual place of abode)

(If nonresident give city, town and State)

Length of residence in city or town where death occurred

yrs.

1

mos.

20

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept. 3rd, 1900.

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

19

8

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

nil Invalid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

St. Mary's Co. (Hollywood) Md.

10 NAME OF FATHER

George W. Lathroum

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Hollywood Md.

12 MAIDEN NAME OF MOTHER

Anna Burroughs

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Hollywood Md.

14

Informant (Address)

Mrs. Anna Lathroum Hollywood St. Mary's Co.

15

JUN 1 - 1920

ROBERT S. LAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 28

1920

17

I HEREBY CERTIFY, That I attended deceased from

May 17th, 1920, to May 28th, 1920,

that I last saw him alive on May 28th, 1920,

and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Hypertensive Pneumonia.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

Benign Hypertension

(duration) 19 yrs. 8 mos. 26 ds.

18 Where was disease contracted if not at place of death?

Hollywood.

Did an operation precede death?

No Date of

Was there an autopsy?

No.

What test confirmed diagnosis?

(Signed) Samuel Whitehouse, M. D.

, 19 (Address) 1392 W. 7th Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mary's Co. Md.

June 2 1920

20 UNDERTAKER

John Albrich

ADDRESS

2008 Calver

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43646

CERTIFICATE OF DEATH.

D43646

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 William St. 24 WARD)

2-FULL NAME

(a) RESIDENCE No. 1024 William St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

JUN 1 - 1920

ROBERT S. ELAETER Registrar

Baltimore City

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1920

17 I HEREBY CERTIFY, That I attended deceased from May 5 1919, to May 29 1920.

That I last saw him alive on May 28 1920.

and that death occurred, on the date stated above, at 12. 9. m.

The CAUSE OF DEATH* was as follows:

Myocardial infarction

CONTRIBUTORY (Secondary)

(duration) 3 yrs. mos. ds. Chronic Interstitial Nephritis

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) M. D. May 31 1920 (Address) 1229 William St.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Brydow Park

6/31 1920

20 UNDERTAKER

ADDRESS

J. J. Faley & Sons

1318 E. 1st St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D43647

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43647

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 230 W. Hill ST.: 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hatter Thomas(a) RESIDENCE. NO. 230 W. Hill ST. 22 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col. 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofOdell Thomas6 DATE OF BIRTH (month, day, and year) 18877 AGE Years Months Days If LESS than 1 day, hrs. or min.
33 ? 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Helper(b) General nature of industry, business, or establishment in which employed (or employer) Meat Packer(c) Name of employer Kriol9 BIRTHPLACE (city or town) Wilmington
(State or country) N.C.10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown14 Informant Odell Thomas
(Address) 230 W. Hill St.

15 JUN 1 - 1920

ROBERT E. LAUTER
RegistrarBurial 11:00 A.M. 1000 RR.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1920

17

I HEREBY CERTIFY, That I attended deceased from May 27, 1920, to May 29, 1920, that I last saw her alive on May 29, 1920, and that death occurred, on the date stated above, at 11 A. m.
The CAUSE OF DEATH* was as follows:Cerebral Hemorrhage(duration) yrs. mos. 3 ds.CONTRIBUTORY Arterio-sclerosis
(Secondary)(duration) ? yrs. ? mos. 7 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) A. J. Hamill M. D.19 (Address) 140 W. Hill St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Wilmington N.C.June 1 1920

20 UNDERTAKER

ADDRESS

J. L. Brown and Son108 W. Montz

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

143648

186✓

143648

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 2573 Greennount Ave ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert A. Loving

(Residence in Baltimore: No. 2573 Greennount Ave St. 25 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word)

6-DATE OF BIRTH March 28, 1886
(Month) (Day) (Year)

7-AGE 34 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Automobile Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) 045

9-BIRTHPLACE (State or country) Maryland

10-NAME OF FATHER Charles A. Loving

11-BIRTHPLACE OF FATHER (State or country) Virginia

12-MAIDEN NAME OF MOTHER Louie Lewis

13-BIRTHPLACE OF MOTHER (State or country) Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles A. Loving

(Address) 2315 Greennount Ave

15-JUN 1 - 1920 ROBERT A. LAUTER
Filed 191 REGISTRAR

Burial Permit 0107

(Over)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH May 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 22nd, 1920, to May 29th, 1920, that I saw him alive on May 29th, 1920, and that death occurred, on the date stated above, at 11:20 P.m. The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) yrs. 5 mos. ds.
Contributory Traumatism of chest
(SECONDARY) (Duration) yrs. 10 mos. ds.

(Signed) Wm Conrad Bode M. D.
June 1st, 1920 (Address) 1900 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Louisa Park DATE OF BURIAL June 1, 1920

20-UNDERTAKER Richard H. Curly ADDRESS 2016 Barclay St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43649

D43649

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Spring Hospital 16* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *700 N. Calhoun* ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *17* yrs. mos. ds. How long in U. S., if of foreign birth? *17* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W.* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Benjamin Franklin*6 DATE OF BIRTH (month, day, and year) *Sept 3-1842*7 AGE Years *77* Months *8* Days *28* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Heathsville* (State or country) *Va*10 NAME OF FATHER *Morton C. Hall*11 BIRTHPLACE OF FATHER (city or town) *Va* (State or country)12 MAIDEN NAME OF MOTHER *Rebecca Harvey*13 BIRTHPLACE OF MOTHER (city or town) *Va* (State or country)14 Informant *Mrs W. J. Jones* (Address) *1114 N. Calhoun St*15 *ROBERT E. BRAUTER* Registrar

JUN 1 - 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 31st 1920*17 I HEREBY CERTIFY, That I attended deceased from *April 1st* 1920, to *May 31st* 1920,that I last saw her alive on *May 30th* 1920,and that death occurred, on the date stated above, at *6:25 A.M.*

The CAUSE OF DEATH* was as follows:

Pneumonia(duration) yrs. *1* mos. *28* ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted *at home* if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Harrell S. Brannen*, M. D.19 (Address) *1727 Edmondson Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

White Marsh Ch. Lancaster Co *June 1st 1920*

20 UNDERTAKER ADDRESS

Bertamby *1723 N. Calhoun St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43650

CERTIFICATE OF DEATH.

REGISTERED NO.

D43650

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 S Chapel ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Symon Rusinek

(a) RESIDENCE, NO.

614 S Chapel ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofFelicia Rusinek

6 DATE OF BIRTH (month, day, and year)

Dec 15 1876

7 AGE

Year

Months

Days

If LESS than
1 day, hrs.

or min.

43516

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Moulder Helper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Stewart Carr

9 BIRTHPLACE (city or town)

(State or country)

Poland

10 NAME OF FATHER

George Rusinek

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Poland

12 MAIDEN NAME OF MOTHER

Agatha Kramiec

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland

14

Informant

(Address)

Felicia Rusinek614 S Chapel

15

JUN 1 - 1920ROBERT E. KRAUTER

Registrar

Burial Permit 01000

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 30, 1920, to May 31, 1920that I last saw him alive on May 30, 1920and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Sudden Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Acute Cardiac Disturbance

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. H. Jones M. D.(Address) 801 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary cemetery June 2 1920

20 UNDERTAKER

ADDRESS

John M. Weber 1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43651

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43651

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1924 Penna Ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Mary Franey(a) RESIDENCE. No. 1924 Penna Ave ST.: 14 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant6 DATE OF BIRTH (month, day, and year) Feb 16/207 AGE Years Months Days If LESS than 1 day, hrs. or min. 3 15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home 000

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balt Md. (State or country)

10 NAME OF FATHER

John Franey11 BIRTHPLACE OF FATHER (city or town) Westminster Md. (State or country)

12 MAIDEN NAME OF MOTHER

Eddie Hoffman13 BIRTHPLACE OF MOTHER (city or town) Balt Md. (State or country)

14

Informant (Address)

John Franey
1924 Penna Ave

15

Filed

JUN 1 - 1920

ROBERT E. CRATER

Baptist Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 192017 I HEREBY CERTIFY, That I attended deceased from May 29 19 20, to May 31 19 20, that I last saw her alive on May 31 19 20, and that death occurred, on the date stated above, at 1:10 P.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Primary)(duration) yrs. mos. ds. 5

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 20Was there an autopsy? NoWhat test confirmed diagnosis? No(Signed) William F. Fry M. D.5/31, 1920 (Address) 1924 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral June 1 1920

20 UNDERTAKER

ADDRESS

Martin F. Fry & Sons 1827 W. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43652

CERTIFICATE OF DEATH.

D43652

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2014 Banks)ST.: 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Catherine V. Brown(a) RESIDENCE. No. 2014 BanksST., 2 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? 17 yrs. 5 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child6 DATE OF BIRTH (month, day, and year) Feb. 23rd 19117 AGE Years 9 Months 3 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

attendant at school

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wachville Tenn. (State or country)

10 NAME OF FATHER

Gar. Brown11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)12 MAIDEN NAME OF MOTHER Sarah J. Roberts13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14

Informant (Address)

John P. Helms
2014 Banks St.

15

JUN 1 - 1920

ROBERT A. FRAUTER

Registrar

Serial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31st 1920

17 I HEREBY CERTIFY, That I attended deceased from

May 28, 1920, to May 31, 1920,that I last saw her alive on May 30, 1920,and that death occurred, on the date stated above, at 140 a. m.

The CAUSE OF DEATH* was as follows:

Gastro EnteritisCONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. 5 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) A. L. Tumbleson M. D.5/31/1920 Address) 2013 Banks

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mount Carmel CemJUN 2 - 1920

20 UNDERTAKER

Lilly & Zeiler

ADDRESS

403 S. W. 40

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43653

CERTIFICATE OF DEATH.

D43653

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3215 E. Baltimore ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary J. Evans

(a) RESIDENCE. NO.

3215 E. Baltimore ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

9

mos.

26

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

aug 31 1919

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.926

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workHome(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Balto
Md.

10 NAME OF FATHER

Frank Evans11 BIRTHPLACE OF FATHER (city or town)
(State or country)Ohio

12 MAIDEN NAME OF MOTHER

anna Snyder13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Ohio

14

Informant
(Address)Francis Evans
3215 E. Baltimore

15

JUN 1 - 1920

ROBERT A. LEAUTEY

Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 30 192017 I HEREBY CERTIFY, I attended deceased from
May 29 1920 to May 30 1920that I last saw her alive on May 30 1920and that death occurred, on the date stated above, at 5p m.

The CAUSE OF DEATH* was as follows:

QuarantineCONTRIBUTORY (Secondary)
Exhaustion
(duration) yrs. mos. ds.
(duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test test of triple
(Signed) Dr. C. C. Cade M. D.
(Address) 1437 N. Broadway*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park CemeteryJune 1st 1920

20 UNDERTAKER

J. G. Moran

ADDRESS

3000 E. Baltimore

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43654

CERTIFICATE OF DEATH.

D43654

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ~~819~~ *Wiltman & F. H. Hall*)

2-FULL NAME

(Residence in Baltimore: No. *819* *W. Carey St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

July *3*, *1865*
(Month) (Day) (Year)

7-AGE,

55 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Mrs. H. H. Hargrave
Hutzler Bros & Co.

9-BIRTHPLACE, (State or Country),

Balto Md

10-NAME OF FATHER,

John

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Mary

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Garland M. Maddy*

(Address) *819 W. Carey St.*

15-

JUNI-1920

ROBERT B. KAUTER

Filed....., 191.....

Serial P. 70 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July *30*, *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I am in charge of the remains described above, held as.....
(Inquest, autopsy or inquiry.)

therein and from the evidence obtained by said.....
(Inquest, au-

opsy or inquiry) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... yrs. mos. ds.

(Signed) *J. E. Hall* M. D.

631, 101 20 address

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Cathedral

June 2, 1920

20-UNDERTAKER

ADDRESS *817 N. Schroeder St.*

H. Brannington

Every item of information should be carefully supplied. AGE should be stated EXACTLY. If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

D43655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 303 N Gilman

ST. 19 WARD)

FULL NAME

Leona Royston

(Residence in Baltimore: No. 303 N Gilman

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 1 mos., 8 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

Sept 12, 1918 (Month) (Day) (Year)

7-AGE,

1 yrs., 8 mos., 17 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

none good

9-BIRTHPLACE, (State or Country),

Baltimore City

10-NAME OF FATHER,

Henry Royston

11-BIRTHPLACE OF FATHER (State or Country),

North Carolina

12-MAIDEN NAME OF MOTHER

Eula Royston

13-BIRTHPLACE OF MOTHER (State or Country),

North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Henry Royston

(Address)

303 N Gilman St

15-

ROBERT K KRAUTER

JUN 1 - 1920

191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 31, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, au-

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Benton M. D. (Coroner.)

May 31, 1920 (Address) 7001 Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL,

St Anns MAY 1 - 1920

20-UNDERTAKER

ADDRESS

JAMES H. DENNIS

1303 PRESTMAN ST

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43656

CERTIFICATE OF DEATH.

154 D43656
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1936 Frederick Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Cole

(Residence in Baltimore: No. 1936 Frederick Ave St.; 74 yrs., 10 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH, July 14, 1845

(Month)

(Day)

(Year)

7-AGE, 74 yrs., 10 mos., 15 ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, House Painter
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md.

10-NAME OF FATHER, Phillip Coley

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Margaret Carmeth

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Caroline Cole

(Address), 1936 Frederick Ave

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 29, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20, 1920, to May 29, 1920, that I saw him alive on May 23, 1920, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration)....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs.....mos.....ds.

(Signed) E. T. Dickey M. D.

May 31, 1920 (Address) 14 N. Howard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, June 1, 1920

20-UNDERTAKER, George Schwab

ADDRESS, 2101 E. Ave

18-

JUN 1 - 1920

ROBERT B. BRAUTER

Burial Permitted

CAUSE OF DEATH is printed in plain terms so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

D43657

HEALTH DEPARTMENT—CITY OF BALTIMORE D43657

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 East 34th ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J. Ansley Justin(Residence in Baltimore: No. 610 East-34th St.; 17 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male4-COLOR OR RACE White5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH, June 15, 1869

(Month)

(Day)

(Year)

7-AGE, 57 yrs., 2 mos., 27 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work Service Manager(b) General nature of industry, business, or establishment in which employed (or employer) Leitz Automobile9-BIRTHPLACE, (State or Country), Georgia10-NAME OF FATHER, George E. Justin11-BIRTHPLACE OF FATHER (State or Country), England12-MAIDEN NAME OF MOTHER Ellie Austin13-BIRTHPLACE OF MOTHER (State or Country), Georgia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Cusher(Address) 610 E 34th St.

15-

Filed JUN 1 - 1920

ROBERT B KAUTER

Burial Home

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 31, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 4 1920, to May 31 1920, that I saw him alive on May 31 1920, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
(Duration) 2 yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Signed) A. F. Robinson M. D.
June 1, 1920 (Address) 1307 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, HomeDATE OF BURIAL, June 2, 192020-UNDERTAKER WilliamsonADDRESS 1039

GROUP OF DEATH IN plain terms, so that it may be properly examined. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43658

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 Harwood Ave ST.; 27 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Clara Parlett Gans

6 DATE OF BIRTH (month, day, and year)

31/10/1863

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56

6

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nursery - 086

(b) General nature of industry, business, or establishment in which employed (or employer)

General Manager

(c) Name of employer

Franklin Gans

9 BIRTHPLACE (city or town) (State or country)

Va -

10 NAME OF FATHER

Franklin Gans

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Michigan

12 MAIDEN NAME OF MOTHER

Mama Kent

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Kent

14

Informant (Address)

Franklin Gans 309 Harwood Ave

15

Filed

JUN 1 1920

ROBERT E. KRAUTER Registrar

Serial Permit 0100

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 25, 1920, to May 31, 1920,

that I last saw him alive on May 30, 1920,

and that death occurred, on the date stated above, at 12:20 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

mitral insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Baltimore

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

clinical signs

(Signed) J. H. Gans M. D.

19 (Address) 2125 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Respect Hill Lawn

June 2 1920

20 UNDERTAKER

ADDRESS

W. J. Gans & Son

North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D43659

H.K. Gomer
Coroner

M.D.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 826 South Pasa St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Wesley Wilhelm

(Residence in Baltimore: No. 826 South Pasa St.; 18 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, March 16, 1845 (Month) (Day) (Year)

7-AGE, 75 yrs., 2 mos., 14 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

10-NAME OF FATHER, John B. Wilhelm

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Helen Stewart

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James M. Wilhelm

(Address) 826 South Pasa St.

JUN 1 - 1920

ROBERT R. ERAUTER

Filed..... 191.....

Serial Permit Required

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 30, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1- 1920, to May 30 1920, that I saw him alive on May 28, 1920, and that death occurred, on the date stated above, at 6:50 p. m. The CAUSE OF DEATH* was as follows:

Senile Arterio Sclerosis

(Duration) 12 yrs., mos., ds.

CONTRIBUTORY Myocardial Degeneration (Secondary)

(Duration) yrs., mos., ds.

(Signed) W. K. Skilling M. D.

May 30, 1920 (Address) 4107 Liberty Hgh.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Glenridge Md June 2, 1920

20-UNDERTAKER, ADDRESS

Wm J. Gickner Son N. Pa

D43660

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43660

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO

ST.: 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 240 S. Chapel

ST.: WARD. 229

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

47 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Marq. Hagan

6 DATE OF BIRTH (month, day, and year)

Dec. 31st 1872

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Foreman

086

(b) General nature of industry, business, or establishment in which employed (or employer)

Columbia Gas

(c) Name of employer

of Home Co.

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

John Hagan

11 BIRTHPLACE OF FATHER (city or town)

Ireland

(State or country)

12 MAIDEN NAME OF MOTHER

Sarah Barr

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore, Md.

(State or country)

14

Informant (Address)

Marq. Hagan 240 S. Chapel St.

15

Filed

JUN 1 - 1920

ROBERT E. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5-30-1920

17

I HEREBY CERTIFY, That I attended deceased from

5-19, 1920, to 5-30, 1920,

that I last saw him alive on 5-29, 1920,

and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Edema of the Lungs

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 8 ds.

18 Where was disease contracted

if not at place of death? 240 S. Chapel St.

Did an operation precede death? Yes Date of 5-20-20

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) S. Payanall, M. D.

19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery 1/2 1920

20 UNDERTAKER

ADDRESS 3000

J. A. Moran & Baltoff

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DECEASED is very important. See instructions on back of certificates.

D43661

CERTIFICATE OF DEATH.

D43661

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebron Road, Home Avenue* ST.; *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Fannie Beumler*(Residence in Baltimore: No. *2619 Kate Ave.* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH, *April 15th*, 18*49*
(Month) (Day) (Year)

7-AGE, *71* yrs., *1* mos., *16* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *House Wife*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER, *Joseph Katz*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER *Beatha Weinberg*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Hall*

(Address) *2117 E. Preston*

15- *JUN 1 - 1920* ROBERT R. KRAUTER

Filed..... 191... *Baltimore* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 31*, 19*20*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *March 1* 19*20*, to *May 30* 19*20*, that I saw her alive on *May 30* 19*20*, and that death occurred, on the date stated above, at *3* p. m.

The CAUSE OF DEATH* was as follows:

Gravine Cancer

(Duration) yrs. *6* mos. ds.

CONTRIBUTORY (Secondary) *Cerebral Anemia*

(Duration) yrs. *2* mos. ds.

(Signed) *Dr. J. J. Smith* M. D.

5/31, 19*20*. (Address) *210 A Smith*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore*

DATE OF BURIAL, *6/2/20*, 191...

20-UNDERTAKER *Gleason & Co. 1611*

ADDRESS *Madison Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec. 6-9-19-H. P. Co.-1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43662

CERTIFICATE OF DEATH.

43

43662

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 N. Castle ST.: 7 WARD)

2-FULL NAME

Mary A. Ogle

(a) RESIDENCE. No. 532 N. Castle ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 9 mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

Widowed or (or) Widowed

Yes. W. Ogle

6 DATE OF BIRTH (month, day, and year)

Aug - 1875

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

44

9

-

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

City

10 NAME OF FATHER

John Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Geo. W. Ogle 532 N. Castle

15

JUN 1 - 1920

ROBERT E. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 1 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 24, 1920, to June 1, 1920,

that I last saw him alive on May 31, 1920,

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast
General Metastasis of
Liver Lung etc.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Acute Cardiac Dilatation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death? Yes Date of June 20

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) F. F. Russell, M. D.

61, 1920 Address 800 N. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Balt. Cem.

June 3 1920

20 UNDERTAKER

Philip Henry

ADDRESS 2016 Orleans

D43663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43663

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 15 ST.; 15 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2001 Poplar Grove St. St.; 10 yrs., mos., ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

M

4-COLOR OR RACE,

W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) M

6-DATE OF BIRTH,

Dec. 17, 1843
(Month) (Day) (Year)

7-AGE,

76 yrs., 5 mos., 14 ds.

If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Retired farmer

9-BIRTHPLACE,
(State or Country),

Carroll Co. Md.

10-NAME OF FATHER,

Peter Koons

11-BIRTHPLACE OF FATHER
(State or Country),

N.J.

12-MAIDEN NAME OF MOTHER

Mary Ott

13-BIRTHPLACE OF MOTHER
(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lawrence Koons

(Address) 2001 Poplar Grove St.

15-

JUN 1 - 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 31, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I saw h. alive on 191

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

acute Dilatation of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

191... (Address)...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Friedrich

DATE OF BURIAL,

June 3, 1920

20-UNDERTAKER

Martin Pahey & Son 1532 W. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43661

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43661

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.: *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ernest Knight

(a) RESIDENCE. No.

Darlington, Md.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

28 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1887

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

33

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Telegraphic Lineman

(b) General nature of industry, business, or establishment in which employed (or employer)

029

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

H. Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

S. Troutman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

University Data Green & Lombard

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 1* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

May 4 19*20* to *June 1* 19*20*

that I last saw him alive on *May 31* 19*20*

and that death occurred, on the date stated above, at *525a* m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) yrs. mos. *10* ds.

CONTRIBUTORY (Secondary) *Cellulitis of leg w/ forearm*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Darlington, Md.*

Did an operation precede death? *yes* Date of *May 4, 20*

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *L. K. Schuerer* M. D.

6/1, 1920 (Address) *University Data*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Darlington Md.

6-3 19*20*

20 UNDERTAKER

ADDRESS

E and B Naebe 115 E West St

JUN 1 - 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43665

CERTIFICATE OF DEATH.

D43665

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1127 Cleveland*)ST. *21* WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Clepton Weber(Residence in Baltimore: No. *1127 Cleveland*)St.; *1* yrs., *0* mos. *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

M

4-COLOR OR RACE,

*W*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word.)

6-DATE OF BIRTH,

May 23, 1919
(Month) (Day) (Year)

7-AGE,

1 yrs. *8* mos. *0* ds.

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Home job

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),*Baltimore*

10-NAME OF FATHER,

*Mr Raymond Weber*11-BIRTHPLACE OF FATHER
(State or Country),*Maryland*

12-MAIDEN NAME OF MOTHER

*Blanche Hayden*13-BIRTHPLACE OF MOTHER
(State or Country),*Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Robert P. Harrison,

15-

Filed *1920*

191

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 31, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 18, 1920, to *May 31, 1920*,that I saw him alive on *May 31, 1920*,and that death occurred, on the date stated above, at *8 P* m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis(Duration).....yrs. *1* mos. *10* ds.CONTRIBUTORY
(Secondary)*Coronary Atherosclerosis*(Duration).....yrs. *3* mos. *0* ds.(Signed) *Edward J. Goulahan* M. D.*6/1/20*, 191... (Address) *3427 Fulton St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.mos.ds. In the State.....yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St Peters Cem**6/2, 1920*

20-UNDERTAKER

ADDRESS

Geo A Farley Fulton & Farley

CAUSE OF DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43666

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43666

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *5100 E. Pratt* St. *1* WARD)

2-FULL NAME

Shaul P. Muel(Residence in Baltimore: No. *2100 E. Pratt St.*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., *Life* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH

May 24, 1924
(Month) (Day) (Year)

7-AGE

3 yrs. *3* mos. *3* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... *None*
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Shaul P. Muel

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Mary E. Muel

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Shaul P. Muel*(Address) *5100 E. Pratt St.*

15-

Robert P. Harrison,

Filed... 1924... 191... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 1, 1924
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, au-*inquest* and that said deceased came to death (Inquest, au-

topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Signed) *Henry G. ...* M. D.
(Coroner) *June 1, 1924* (Address) *1610 E. Pratt St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

19-Former or usual residence.....

20-PLACE OF BURIAL OR REMOVAL

Lorraine Cem. DATE OF BURIAL, *June 2, 1924*

21-UNDERTAKER

H. Sanders Sons ADDRESS *1710 Fleet St.*

K.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION is very important. See instructions on back of certificate.

JUN 1 - 1924

D43667

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43667

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital*)ST. *7*

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Christopher

(a) RESIDENCE. NO.

837 Hollins St

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *0* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *0* yrs. *0* mos. *0* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years *0* Months *0* Days *0* If LESS than 1 day, 7 hrs. or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*(b) General nature of industry, business, or establishment in which employed (or employer) *None*(c) Name of employer *None*9 BIRTHPLACE (city or town) *Balto. Md*
(State or country)10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) *Unknown*
(State or country)12 MAIDEN NAME OF MOTHER *Agnes Christopher*13 BIRTHPLACE OF MOTHER (city or town) *Balto. Md*
(State or country)

14

Informant (Address) *R. A. Johnston*

15

Filed

Robert P. Harrison

Registrar

JUN 1 - 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *5-28* 19 *20*17 I HEREBY CERTIFY, That I attended deceased from *May 28*, 19 *20*, to *May 28*, 19 *20*, that I last saw him alive on *May 28*, 19 *20*, and that death occurred, on the date stated above, at *5:30 P. m.*

The CAUSE OF DEATH* was as follows:

Toxemia due to Eclampsia of Mother.(duration) *—* yrs. *—* mos. *—* ds.

CONTRIBUTORY (Secondary)

(duration) *—* yrs. *—* mos. *—* ds.18 Where was disease contracted if not at place of death? *—*Did an operation precede death? *—* Date of *—*Was there an autopsy? *yes.*What test confirmed diagnosis? *—*(Signed) *Chas. Harris*

M. D.

Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*JOHNS HOPKINS HOSPITAL**JUN 1 - 1920*

20 UNDERTAKER

ADDRESS

Commissioner Health

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43668

D43668

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
- (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed..... 191.....

Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 19, 1920, to May 30, 1920, that I saw him alive on May 30, 1920 and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

M. D. 1912 Address 724 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

JOHNS HOPKINS HOSPITAL..... 191...

20-UNDERTAKER

ADDRESS

Commissioner Health,

JUN 1 - 1920

Burial Permit Clerk.

D43669
140180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43669

CERTIFICATE OF DEATH.

x 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *James Hopkins Hospital* ST. *7th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Emory Akers

(a) RESIDENCE. NO.

(Usual place of abode)

7000 W. St.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

May 17 - 1900

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*20**15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Edward S. Akers

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

ind

12 MAIDEN NAME OF MOTHER

May Summers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

ind

14

Informant (Address)

7th. Records

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 1st* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

April 10 19*20*, to *June 1st* 19*20*.that I last saw him alive on *June 1st* 19*20*.and that death occurred, on the date stated above, at *9:20 a.m.*

The CAUSE OF DEATH* was as follows:

Myocardial infarction(duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

Initial stenosis(duration) *2* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *yes*(Signed) *Dr. H. H. Friedman* M. D., 19 (Address) *Town Hopkins Hosp*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Palston Md**June 2* 19*20*

20 UNDERTAKER

ADDRESS

H. J. Tinkner Sons

CAUSE OF DEATH in plain terms, so that it may be properly classified. Fact stated on back of certificate. See instructions on back of certificates.

JUN 1 - 1920

D43670

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43670

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (IN)

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I am in charge of the remains described above, held an

thereon and from the evidence obtained by said

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) M. D.

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. da. State.... yrs. mos. da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

JUN 1 - 1920

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43671

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43671

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Mercy Hospital* ST. *4* WARD)FULL NAME *Mrs. Dora Belair*(Residence in Baltimore: No. *Belair mo*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

(Month) (Day) (Year) *1*

7-AGE,

9

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer) *room - opp*

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER, *J. J. Duncan*11-BIRTHPLACE OF FATHER (State or Country), *Pa.*12-MAIDEN NAME OF MOTHER, *Sadie Barrett*13-BIRTHPLACE OF MOTHER (State or Country), *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Hospital Records*(Address) *Hospital Records*

15-

Robert P. Harrison,

JUN 1 1920

Burial Permit Clerk

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 1, 1920*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) And that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull, struck by auto at Belair, Md.(Duration) yrs. mos. ds. *2*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. *2*(Signed) *J. J. Duncan*

(Coroner) M. D.

6-1, 1920 (Address) *117 W. Saratoga*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Lawrence, Pa.*DATE OF BURIAL, *June 2, 1920*

20-UNDERTAKER

ADDRESS

*Harry H. Hitzke**1530 W. Lombard*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

D43672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 D43672

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3728 Eastern Ave ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

George Matzger

(a) RESIDENCE. No.

3728 Eastern

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

48 yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Anna Matzger

6 DATE OF BIRTH (month, day, and year)

Apr 25 1875

7 AGE

75

Years

Months

Days

If LESS than

1 day, hrs.

or min.

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cooper 086

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired 086

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Germany

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Germany

14

Informant
(Address)Geo Matzger Jr
3728 Eastern Ave

15

JUN 2 - 1920

ROBERT A. TRAUTER

Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1920

17

I HEREBY CERTIFY, That I attended deceased from
April 9, 1920, to May 29, 1920,
that I last saw him alive on May 29, 1920,
and that death occurred, on the date stated above, at 9:25 P. M.
The CAUSE OF DEATH* was as follows:

Intestinal Carcinoma

(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)

Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. A. Glantz, M. D.

, 19 (Address) 3244 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Carmel Cemetery

June 8 1920

20 UNDERTAKER

J. Herwig & Co

ADDRESS

2008 Klean

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43674

CERTIFICATE OF DEATH.

D43674

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 East Pratt

ST.: 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1411 East Pratt St

St.: 14 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-STATUS,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH,

— — 1848
(Month) (Day) (Year)

7-AGE,

72 yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Story-keeper
Confectioner9-BIRTHPLACE,
(State or Country),

Rumania

PARENTS.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER
(State or Country),

Rumania

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or Country),

Rumania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

JUN 2 - 1920
Filed... 191...
ROBERT B KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 1, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 28, 1920, to June 1, 1920,

that I saw him alive on May 31, 1920,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration)...

CONTRIBUTORY...

(Duration)...

(Signed)...

8/1-20, 191... (Address)...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Greenwood Cemetery

20-UNDERTAKER,

Jack Lewis, 1411 E. Pratt

DATE OF BURIAL,

June 2, 1920

ADDRESS

1411 E. Pratt St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

043675

CERTIFICATE OF DEATH.

170 043675

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 S. Sixth ST. 76 WARD)

2-FULL NAME

Mary M. Bornemann

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

821 S. Sixth ST. 76 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofMr Bornemann

6 DATE OF BIRTH (month, day, and year)

Oct. 18, 1831

7 AGE

88713If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Germany

10 NAME

Henry Sparidogian

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

(Address)

Lena Daffner
821 S. Sixth St

15

Filed

JUN 2 - 1920

ROBERT E. FLAHERTY

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 31 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 1919, to May 31, 1920that I last saw him alive on May 30, 1920and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? UnknownDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Albumen(Signed) J. A. Glatz, M. D., 1920 (Address) 3244 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount OlivetJune 2 1920

20 UNDERTAKER

Gorkler & Gorkler

ADDRESS

1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Elias J. Harris
HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D43676

CERTIFICATE OF DEATH.

40 D43676
REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *326 Hoffman* ST.; *12* WARD)
2-FULL NAME *Elias J. Harris*
(Residence in Baltimore: No. *326 Hoffman* St.; *33* mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. *Male* 4-COLOR OR RACE, *Cauc* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*
6-DATE OF BIRTH, *Feb 2 1836*, 1 (Month) (Day) (Year)

7-AGE, *84* yrs. *4* mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Private 086*
(b) General nature of industry, business, or establishment in which employed (or employer). *Bulbs*

9-BIRTHPLACE, (State or Country), *MD*

10-NAME OF FATHER, *George Harris*
11-BIRTHPLACE OF FATHER (State or Country), *MD*
12-MAIDEN NAME OF MOTHER, *Unknown*
13-BIRTHPLACE OF MOTHER (State or Country), *MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Man 2 H. Wilkin*
(Address) *326 Hoffman*

15- *JUN 2 - 1920* 191. *ROBERT A. KRAUTER*
Filed *Bureau of Health*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 18*, *1920* (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *June 18 1920* to *June 18 1920* that I saw him alive on *May 31 1920* and that death occurred, on the date stated above, *8:15 PM*
The CAUSE OF DEATH* was as follows:

By apoplexy
(Duration) *8* yrs. *8* mos. ds.
CONTRIBUTORY (Secondary) *old age*
(Signed) *A. P. Ellis* M. D.
(Address) *72 Lomb*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Laural City* DATE OF BURIAL, *June 3 1920*
20-UNDERTAKER, *George H. Collins* ADDRESS, *1631 W. 11th Ave*

important. See instructions on back of certificate.

D43678

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43678

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

146 W. Hanbury ST. 23 WARD

2-FULL NAME

Marie Gantt

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

146 W. Hanbury ST. 23 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

21 yrs. 5 mos. 26 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 4 1898

7 AGE

Years

21

Months

5

Days

26

If LESS than
1 day. hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic 870

(b) General nature of industry, business, or establishment in which employed (or employer)

Porters

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Ind

10 NAME OF FATHER

Thos Gant

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Ind

12 MAIDEN NAME OF MOTHER

Victoria Clarke

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Ind

14

Informant
(Address)Estella Gant
603 Wayne St.

15

JUN 2 - 1920

ROBERT E. FLAHERTY

BIRTH PERMIT OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

5/30/1920

17

I HEREBY CERTIFY, That I attended deceased from

May 21st 1920, to May 30th 1920.that I last saw him alive on May 30th 1920.

and that death occurred, on the date stated above, at 8:52 P.M.

The CAUSE OF DEATH* was as follows:

Acute Ailment, No

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Acute Bronchitis
about 2 mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Clinical

(Signed)

6/1/20 (Address) 90 S. Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn

June 3 1920

20 UNDERTAKER

Jas. H. Loder

ADDRESS 142
W. 11th St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43679

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91

D43679

PLACE OF DEATH

CITY OF BALTIMORE (No. 535 W. Laverne St. 17 WARD)

2-FULL NAME Herbert Thomas

(Residence in Baltimore: No. 535 W. Laverne St. yrs. 6 mos. 8 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, Black 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, November 24, 1919 (Month) (Day) (Year)

7-AGE, 6 yrs. 8 mos. 8 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, none (b) General nature of industry, business, or establishment in which employed (or employer), none

9-BIRTHPLACE, (State or Country), Balto, Md.

10-NAME OF FATHER, Herbert Thomas

11-BIRTHPLACE OF FATHER (State or Country), Balto, Md.

12-MAIDEN NAME OF MOTHER, Lena Thompson

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena Thompson

(Address) 535 W. Laverne

15- JUN 2 - 1920 ROBERT E. KRAUTER

16- BUTLER STREET

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Brucella pneumonia (Duration) 2 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs. 2 mos. 2 ds.

(Signed) J. S. Hennessy M. D. (Coroner.)

June 1, 1920 (Address) 2802 Edgewood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. 2 mos. 2 ds. In the State 2 yrs. 2 mos. 2 ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Colum DATE OF BURIAL, June 2, 1920

20-UNDERTAKER, Daniel Easton ADDRESS 516

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43680

CERTIFICATE OF DEATH

STILL BIRTH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Rsk Cross Street in Baltimore*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Cold Spring Lane near York Rd*)St. *1* yrs. *0* mos. *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>male</i>	4-COLOR OR RACE, <i>white</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, <i>May 29</i> , 1920 (Month) (Day) (Year)		
7-AGE, <i>8 1/2 hours</i> If LESS than 1 day, <i>8 hrs. or 30 min.?</i> yrs. mos. da.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>None</i> (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE, (State or Country), <i>Baltimore Md</i>		
PARENTS.	10-NAME OF FATHER, <i>Harry D. Urban</i>	
	11-BIRTHPLACE OF FATHER (State or Country), <i>New Jersey</i>	
	12-MAIDEN NAME OF MOTHER, <i>Margaret Rogers</i>	
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Georgia</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

JUN 2 - 1920

ROBERT E. KRAUTER

191.

BRIAN P. M. R. R.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 29, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 29*, 1920, to *May 29*, 1920, that I saw him alive on *May 29*, 1920, and that death occurred, on the date stated above, at *1.30 P. m.*

The CAUSE OF DEATH* was as follows:

Perinatal death - 6 months gestation
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)(Signed) *G. H. Williams* M. D.
5/31, 1920. (Address) *505 York Rd*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Carnegie Embroidery Shop

DATE OF BURIAL,

....., 191...

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43681

CERTIFICATE OF DEATH.

64 D43681

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

32 Ailsa ave

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Annie A. Clarkson

(a) RESIDENCE. NO.

32 Ailsa ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

92 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 12/1828

7 AGE

92

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Spinster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Co Md

10 NAME OF FATHER

Joseph Clarkson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

England

12 MAIDEN NAME OF MOTHER

Caroline H. Wilson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Harford Co Md

14

Informant (Address)

A. Albert Clarkson
32 Ailsa ave

15

JUN 2 - 1920

ROBERT H. FRAUTER

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 1st 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 1, 1920, to June 1, 1920

that I last saw her alive on June 1, 1920.

and that death occurred, on the date stated above, at 1:45 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at place of death

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) George H. Long M. D.

19 (Address) 27 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery

June 3rd 1920

20 UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E. Monument St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DEATH is very important. See instructions on back of certificates.

D43682

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43682

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.; *W* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *Baltimore, Md* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Married

6 DATE OF BIRTH (month, day, and year)

June 1, 1857

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

63

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

H. Wagner

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Amy Wagner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

University Hospital Records

15

JUN 2 - 1920

ROBERT R. KRAUTER

Registrar

Burial Permit *0100*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 1st 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*May 29, 1920, to June 1, 1920,*that I last saw him alive on *June 1, 1920,*and that death occurred, on the date stated above, at *10:30 P. m.*

The CAUSE OF DEATH* was as follows:

Renal Insufficiency(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

Hypertrophied Prostate

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *May 30, 1920*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

Cyrus J. Horne, M. D.

, 19 (Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Annapolis Md.**June 2 1920*

20 UNDERTAKER

Jas S. Taylor, Seno

ADDRESS

Annapolis Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43683

D43683

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Josephs Hospital* ST.: *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *750 Haescher St.* ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *25* yrs. mos. ds. How long in U. S., if of foreign birth? *42* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Col.* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced *Widowed*
(or) WIFE of *Harry Murray*6 DATE OF BIRTH (month, day, and year) *— 1870*7 AGE *50* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Carlisle Co. Md.*
(State or country)10 NAME OF FATHER *Mr. Kuan*11 BIRTHPLACE OF FATHER (city or town)
(State or country) *Un Known*12 MAIDEN NAME OF MOTHER *Betty Williams*13 BIRTHPLACE OF MOTHER (city or town)
(State or country) *Id.*14 Informant *Augusta Fields*
(Address) *578 Preston St.*15 Filed *JUN 2 - 1920* ROBERT E. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 31 1920*17 I HEREBY CERTIFY, That I attended deceased from *May 21*, 19*20*, to *May 31*, 19*20*,
that I last saw her alive on *May 31*, 19*20*,
and that death occurred, on the date stated above, at *8 P* m.

The CAUSE OF DEATH* was as follows:

Surgical shock following operation for removal of a large gall stone(duration) yrs. mos. *1/2* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted?

If not at place of death?

Did an operation precede death? *Yes* Date of *May 31/20*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Charles S. Crook*, M. D.19 (Address) *St Josephs Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

W. T. Auburn JUN 3 - 1920

20 UNDERTAKER

ADDRESS

*JAMES H. DENNIS**1303 PRESTMAN ST.*

STATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43687

CERTIFICATE OF DEATH.

37 D43687

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 Bruce

ST. 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Albert Johnson

(Residence in Baltimore: No. 1630 Bruce

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) baby

6-DATE OF BIRTH,

May 25, 1920
(Month) (Day) (Year)

7-AGE,

t yrs. t mos. 6 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

baby

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

William Johnson

11-BIRTHPLACE OF FATHER

(State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Estelle Hill

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

William Johnson

(Address)

1630 Bruce

15-

JUN 2 - 1920

ROBERT E. KRAUTER

Burial

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

May 31, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 25 1920, to May 31 1920, that I saw him alive on May 31 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis

(Duration) t yrs. t mos. 2 ds.

CONTRIBUTORY (Secondary)

Congenital Paresis

(Duration) t yrs. t mos. ds.

(Signed)

Charles E. Clark

May 31 1920 (Address) 1306 S. 19th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt Auburn

DATE OF BURIAL

JUN 2 - 1920

20-UNDERTAKER

JAMES H. DENNIS

1303 PRESTMAN ST.

Circled or underlined in plain text, so that it may be properly classified. Enter statement of OCCUPATION in plain text. See instructions on back of certificate.

D43685

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43685

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.: *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Beatrice Smith

(a) RESIDENCE. NO.

Marley A. A. Co. Md.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

2 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Charles W. Smith*

6 DATE OF BIRTH (month, day, and year)

1881

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

39

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Md.*

10 NAME OF FATHER

*Urias Williams*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Md.*

12 MAIDEN NAME OF MOTHER

*Mary M. Spencer*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Md.*

14

Informant
(Address)*Hospital Records
University Hospital*

15

Filed

*JUN 2 1920**ROBERT A. KRAUTER*

Registrar

Barial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *May 31 1920*

17

I HEREBY CERTIFY, That I attended deceased from

May 30 1920, to *May 31 1920*.that I last saw her alive on *May 31 1920*.and that death occurred, on the date stated above, at *6.15 P. m.*

The CAUSE OF DEATH* was as follows:

Eclampsia (ante partem)(duration) yrs. mos. *1* da.CONTRIBUTORY *Acute Pulmonary Edema*
(Secondary)(duration) yrs. mos. *1* da.

18 Where was disease contracted

if not at place of death?

*Marley A. A. Co. Md.*Did an operation precede death? *Yes* Date of *May 30 1920*

Was there an autopsy?

What (est confirmed diagnosis) *Clinical Findings*(Signed) *J. A. Buchness*, M. D.19 (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Marley A. A. Co. Md.**June 3 1920*

20 UNDERTAKER

ADDRESS

*Joseph A. Farrel**234 Union*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43686

D43686

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1207 Rahorg* ST.; *19* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Columbus Dutton*(Residence in Baltimore: No. *1207 Rahorg* St.; *Lifetime* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*4-COLOR OR RACE. *Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)6-DATE OF BIRTH. *July 25, 1919*

(Month) (Day) (Year)

7-AGE. *10 yrs. 6 mos. 6 ds.*

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE. *Balto. Md.*
(State or Country).10-NAME OF FATHER. *Columbus Dutton*11-BIRTHPLACE OF FATHER. *Howard Co. Md.*
(State or Country).12-MAIDEN NAME OF MOTHER. *Ella Howard*13-BIRTHPLACE OF MOTHER. *Maryland*
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ella Dutton*(Address) *1207 Rahorg St.*

15-

Filed *JUN 2 - 1920*

ROBERT E. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *May 31, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 25, 1920* to *May 31, 1920*, that I saw him alive on *May 31, 1920*, and that death occurred, on the date stated above, at *11:30 p.m.*

The CAUSE OF DEATH* was as follows:

Acute Bronchitis(Duration) *Over 1 week*CONTRIBUTORY (Secondary) *None*(Duration) *5 yrs. 6 mos. 6 ds.*(Signed) *Henry C. O'Neil*(Address) *1203 W. Fayette St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. *10 yrs. 6 mos. 6 ds.* In the State *10 yrs. 6 mos. 6 ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. *mt auburn cemetery*DATE OF BURIAL. *June 5, 1920*20-UNDERTAKER. *Joseph A. Farrell*ADDRESS. *2319 Division*

Check of death in plain terms so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

D43687

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

D43687

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Mulotski(a) RESIDENCE. NO. 1044 Granby St.ST. 3 WARD.

(Usual place of abode)

Unknown

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)MaleWhiteMarried5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 1845.

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.75

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workLaborer(b) General nature of industry,
business, or establishment in
which employed (or employer)Unknown

(c) Name of employer

Unknown9 BIRTHPLACE (city or town).
(State or country)Russia

10 NAME OF FATHER

Jos. Mulotski11 BIRTHPLACE OF FATHER (city or town).
(State or country)Russia12 MAIDEN NAME OF MOTHER ? Sevilki13 BIRTHPLACE OF MOTHER (city or town).
(State or country)Russia

14

Informant
(Address)Hospital RecordsM.T.H.

15

JUN 2 - 1920ROBERT A. KAUTER
RegistrarBurial Permit 0100

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 24, 1920, to May 31, 1920,that I last saw him alive on May 31, 1920,and that death occurred, on the date stated above, at 10.50 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 3 yrs. 6 mos. ds.CONTRIBUTORY
(Secondary)(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis T.B. in sputum, X-ray(Signed) George W. Unknown, M. D.5-31-20, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Vincent's Cem.6/2 1920

20 UNDERTAKER

ADDRESS

Chas. F. Evans & Son 118 N. W. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43688

CERTIFICATE OF DEATH.

D43688

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1724 W Lafayette St.)

ST.:

WARD) 16

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Lidie O Kemp

(Residence in Baltimore: No. 1724 W Lafayette Ave)

St.:

Lafayette

mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F

4-COLOR OR RACE,

W

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Oct

20

1839

(Month)

(Day)

(Year)

7-AGE,

80

yrs.

1

mos.

11

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Kemp Beckley

11-BIRTHPLACE OF FATHER
(State or Country),

Prussia

12-MAIDEN NAME OF MOTHER

Hannah Brooks

13-BIRTHPLACE OF MOTHER
(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Mrs. H. A. Hill

(Address).....

1724 W Lafayette Ave

15-

Filed

JUN 2 - 1920

ROBERT A. KRAUTER

Baptist Church, Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 1

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I saw h..... alive on

191

and that death occurred, on the date stated above, at..... m.

The CAUSE OF DEATH* was as follows:

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. Is the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Lafayette Ave

June 3, 1920

UNDERTAKER

ADDRESS

Baltimore, Md. 1724 W Lafayette Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43689

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *559 Warwick St.*)

79 REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *559 Warwick St.*)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*col*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

unknown, 1868
(Month) (Day) (Year)

7-AGE,

52 yrs. mos. ds.If LESS than 1 day,
.... hrs. of min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *laborer*
(b) General nature of industry, business, or establishment in which employed (or employer) *040*9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John H. Liverpool*(Address) *559 Warwick St.*

15-

JUN 2 - 1920 ROBERT B. KAUTER
Filed..... 191... 8-24-14... REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

May 31, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 4* 1920, to *May 31* 1920, that I saw him alive on *May 30* - 1920, and that death occurred, on the date stated above, at *2 A* m.

The CAUSE OF DEATH* was as follows:

*Valvular heart lesions*CONTRIBUTORY
(Secondary)(Signed) *W. J. Coleman* M. D.*May 31*, 1920 (Address) *2039 Mc Clellan*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

St. Agnes *June 2*, 1920
Sam'l. Demsey *578 N. Biddle*

Check of death in plain terms, so that it may be properly classified. Enter statement of occupation in very important. See instructions on back of certificate.

Winifred Lavin

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43690

CERTIFICATE OF DEATH.

88

D43690

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp. ST.; 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winifred Lavin(a) RESIDENCE. NO. 324 E 21st St ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female whiteSingle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE

Years

Months

Days

If LESS than 1 day, ____ hrs. or ____ min.

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Machine Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

069

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. County10 NAME OF FATHER Patrick Lavin

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland12 MAIDEN NAME OF MOTHER Anna Lavin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Wash. Md.

14

Informant (Address)

Patrick Lavin
324 E. 21st St.

15

Filed

JUN 2 - 1920ROBERT A. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1920

17

I HEREBY CERTIFY, That I attended deceased from April 20, 1920, to May 31, 1920, that I last saw him alive on May 31, 1920and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Myocardial infarction(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

Acute Myocardial Infarction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 31-20Was there an autopsy? No

What test confirmed diagnosis?

Thyroid gland removed

(Signed)

J. T. O'Connell, M. D.

, 19

(Address)

St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Joseph Texas Md.June 3, 1920

20 UNDERTAKER

ADDRESS

Richard H. Conley2016 Barclay St.

Burial Permit Blank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43691

D43691

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3045 Guilford ave. ST. 17 WARD)

2-FULL NAME Leatharine Gordon

(Residence in Baltimore: No. 3045 Guilford ave

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

44 15 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH,

2

2

1834

(Month)

(Day)

(Year)

7-AGE,

86

yrs.

mos.

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

Lady

9-BIRTHPLACE, (State or Country),

Perry Co. Ohio

10-NAME OF FATHER,

John B. Bingham

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles E. Gordon

(Address) 3045 Guilford ave

15-JUN 2 - 1920 ROBERT B. KRAUTER

Filed..... 191... 8

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 24, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) John B. Bingham M. D.

(Address) 3632 R. Lane

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, DATE OF BURIAL,

St. Mary's Cemetery June 24, 1920

20-UNDERTAKER

Henry J. Williams

ADDRESS

116 E. Calhoun

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43693

D43693

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 Mc Cabe Ave Gorans 27 WARD)

REGISTERED NO. C.

2-FULL NAME

(Residence in Baltimore: No. 716 Mc Cabe Ave - Gorans St. - yrs. 5 mos. 27 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, Married
(Write the word.)

6-DATE OF BIRTH, November 13; 1857
(Month) (Day) (Year)

7-AGE, 63 yrs. 6 mos. 22 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. at Home
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Whitman - Mass

10-NAME OF FATHER, Samson Fullerton

11-BIRTHPLACE OF FATHER (State or Country), Whitman - Mass

12-MAIDEN NAME OF MOTHER Ellen C. Skid.

13-BIRTHPLACE OF MOTHER (State or Country), New York State

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles H. Sambalino(Address) 716 Mc Cabe Ave

15-

Filed Robert P. Harrison 101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 24 1912, to June 1 1912, that I saw her alive on May 31 1912, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Coma
Superinduced by Diabetes
do not know
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Coma

(Signed) E. H. Duncan M. D.
June 1, 1912 (Address) Gorans St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence New York City

19-PLACE OF BURIAL OR REMOVAL,

New York

DATE OF BURIAL,

June 3, 1912

20-UNDERTAKER

William Cook

ADDRESS

602 E. North Ave

UN2-1920

D43691

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43691

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE

No. 427 Calver Ave

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John F. MacKenzie

(a) RESIDENCE

No. 427 Calver Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

Emily January 1847

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

73

1

5-

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

100

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

John MacKenzie

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Scottland

12 MAIDEN NAME OF MOTHER

Emily January

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Penn

14

Informant (Address)

John MacKenzie 427 Calver Ave

15

Filed

JUN 2 - 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 2 1920

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 1918, to June 2, 1920,

that I last saw him alive on June 1, 1920,

and that death occurred, on the date stated above, at 4:40 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis agitans

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

510 Willow Ave

if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

W. C. H. H. H.

M. D.

, 19

(Address)

1600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mary's

20 UNDERTAKER

J. M. Cook

ADDRESS

1600 York Rd.

D43695

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43695

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Melvin Porter

(a) RESIDENCE. NO.

412 Bones Alley ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

Life mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mich. 14-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2 mo.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

C. Laid

(b) General nature of industry, business, or establishment in which employed (or employer)

ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Sam Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country)

B.

12 MAIDEN NAME OF MOTHER

Eileen Porter

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

J. H. H. BrandsRobert J. Harrison

JOHNS

JUN 2 - 1920

Burial Permit clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1920

17

I HEREBY CERTIFY, That I attended deceased from May 21, 1920, to May 27, 1920, that I last saw him alive on May 27, 1920, and that death occurred, on the date stated above, at 1:5 a. m.

The CAUSE OF DEATH* was as follows:

Heart failure(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

No Date of

Was there an autopsy?

What test confirmed diagnosis?

Chest
W. J. H. H. M. D.

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITALJUN 1 - 1920

20 UNDERTAKER

ADDRESS

Commissioner Health

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43696

D43696

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widower

6-DATE OF BIRTH.

March 3, 1857
(Month) (Day) (Year)

7-AGE.

63 yrs., 2 mos., 21 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

General 040

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE, (State or Country).

Harford Co. Md.

PARENTS.

10-NAME OF FATHER.

Unknown

11-BIRTHPLACE OF FATHER (State or Country).

Unknown

12-MAIDEN NAME OF MOTHER

Ollera Waters

13-BIRTHPLACE OF MOTHER (State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

Robert P. Harrison,

Burial Permit Clerk,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

May 24, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

February 29, 1920, to May 24, 1920,

that I saw him alive on May 23, 1920,

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac failure - Thrombosis
Left External Iliac vein - Gangrene -
Endocarditis (mitral) - Rouchia -
Pneumonia. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Influenza
(Duration) yrs. mos. ds.

(Signed)

William J. Stewart, M. D.
5/24, 1920 (Address) Md. Penitentiary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 12 yrs., 7 mos., 13 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

919 Jordan St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

JONES & SONS Health.

ADDRESS

JUN 2 - 1920

CASE OF DEATH IN plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificate.

D43697

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D43697

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3766 Cascora

ST.: 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Levin A. Connor

(a) RESIDENCE. No.

3766 Cascora

ST.: 20 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

5 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 23 - 1847

7 AGE

73

Years

Months

Days

If LESS than 1 day, hrs. or min.

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None 088

(b) General nature of industry, business, or establishment in which employed (or employer)

(Was Shoemaker)

(c) Name of employer

9 BIRTHPLACE (city or town) State or country

Md

10 NAME OF FATHER

Sam'l Connor

11 BIRTHPLACE OF FATHER (city or town) State or country

Md

12 MAIDEN NAME OF MOTHER

E. Corsley

13 BIRTHPLACE OF MOTHER (city or town) State or country

Md

14

Informant (Address)

J. L. Connor 3766 Cascora

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 2 1920

17

I HEREBY CERTIFY, That I attended deceased from

Month 1920, to June 2, 1920,

that I last saw him alive on June 1, 1920,

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal
reptile

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 20 Date of

Was there an autopsy? 20

What test confirmed diagnosis? General

(Signed) W. A. Ruel, M. D.

, 19 (Address)

Bryant

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

George W. Smith 3766 Cascora

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 2 - 1920

D43698

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43698

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2114 Suzanne ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

Robert P. Harrison,

JUN 2 - 1920

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1920

17

I HEREBY CERTIFY, That I attended deceased from
May 29, 1920, to June 1, 1920,
that I last saw him alive on June 1, 1920,
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
acute gastritis
own

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. Harrison, M. D.2, 1920 (Address) 2008 Baltimore*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Olivet CemeteryJune 3 1920

20 UNDERTAKER

ADDRESS

J. Herwig & Co.2008 Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43699

103 D43699

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Decatur ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Era M Johnson(a) RESIDENCE. NO. 1416 Decatur ST. 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds.How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 25-1918

7 AGE

Years 2Months 6Days 6

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child(b) General nature of industry, business, or establishment in which employed (or employer) 100

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) md10 NAME OF FATHER Edward Johnson11 BIRTHPLACE OF FATHER (city or town) Balt (State or country) md12 MAIDEN NAME OF MOTHER Helena Senary13 BIRTHPLACE OF MOTHER (city or town) Balt (State or country) md

14

Informant (Address) Helena Johnson
1416 Decatur St

Robert P. Harrison,

, 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 192817 I HEREBY CERTIFY, That I attended deceased from May 31 - May 31, 1920,
that I last saw her alive on May 31, 1920,
and that death occurred, on the date stated above, at 11:50 P.M.
The CAUSE OF DEATH* was as follows:Acute Dilatation of HeartCONTRIBUTORY - Acute Gastritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. White M. D., 19 (Address) 1297 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Waller's Lmt & Jun 3 1928

20 UNDERTAKER

ADDRESS

W. H. White & Co

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 2 1920

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact Statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43700

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D43700

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 W. 37

ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sarah E Cottrell

(a) RESIDENCE

No. 1023 W. 37

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

70 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 3, 1839

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

81

2

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stone

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pennsylvania

10 NAME OF FATHER

Eli Cottrell

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Frederick Co. Md

12 MAIDEN NAME OF MOTHER

Sarah Strohm

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Pennsylvania

14

Informant

(Address)

S. Fiegler

311 Madison St

15

Filed

Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1920

17

HEREBY CERTIFY, That I attended deceased from

Oct 1, 1918, to June 1, 1920.

that I last saw her alive on May 31, 1920.

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Walter E. Cottrell, M. D.

(Address) 54 S. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park

June 3 1920

20 UNDERTAKER

Geo W. Little

ADDRESS

531 N. Fremont

D43701

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43701

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 Heckley Place ST.: 8 WARD)

2-FULL NAME

Milton H. Miller

(a) RESIDENCE. No.

1601 Heckley Place ST.: _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 4mos. 1

ds. _____

How long in U. S., if of foreign birth?

yrs. 4

mos. _____

ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Child5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____6 DATE OF BIRTH (month, day, and year) March 1st 1920

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.4

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workHome 000(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore
Ind

10 NAME OF FATHER

Harry Miller11 BIRTHPLACE OF FATHER (city or town)
(State or country)Baltimore

12 MAIDEN NAME OF MOTHER

Bertha Preston13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Baltimore

14

Informant
(Address)Bertha Miller
1601 Heckley Place

15

Filed

Robert P. Harrison

Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 19 20

17

I HEREBY CERTIFY, That I attended deceased from

May 29, 1920, to June 2, 1920.that I last saw him alive on June 1, 1920.and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Broncho PneumoniaMarasmus(duration) yrs. _____ mos. 4 ds.CONTRIBUTORY
(Secondary)(duration) yrs. _____ mos. 4 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) D. G. W. Kennard M. D.June 2 1920 (Address) 708 E. 8th St.*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery June 4 1920

20 UNDERTAKER

ADDRESS

Mr. Wm. T. Hartley 2334 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 2 - 1920

141128 HEALTH DEPARTMENT—CITY OF BALTIMORE

D43702

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *John Hopkins Hospital* ST. *7th* WARD)2-FULL NAME *May Ellen Cleish*(a) RESIDENCE. No. *722 N. Curley St.* ST. _____ WARD. _____

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

Life

ds.

How long in U. S., if of foreign birth?

yrs.

13

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April 24 - 1919*7 AGE Years *1* Mos. *10* Days *8* If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

OOD

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

John Cleish

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Amelia Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*Baltimore*14 Informant *J. H. H. Records* (Address)15 Filed *Robert P. Harrison,*

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *6-1* 19*20*17 I HEREBY CERTIFY, That I attended deceased from *May 25*, 19*20*, to *June 1*, 19*20*, that I last saw him alive on *June 1*, 19*20*, and that death occurred, on the date stated above, at *9:15 P. m.*

The CAUSE OF DEATH* was as follows:

Measles(duration) yrs. *1* mos. *21* ds.CONTRIBUTORY *Broncho-pneu-* (Secondary) *monee* (duration) yrs. *1* mos. *14* ds.18 Where was disease contracted If not at place of death? *Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physiase Signs*(Signed) *Harold L. Huggins M. D.*6/2 1920 Address *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Oak Lawn Cemetery June 4 1920

20 UNDERTAKER ADDRESS

Ans. C. Fuller *2334 Jefferson*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 2 - 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43703

CERTIFICATE OF DEATH.

92043703

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from May 23rd, 1920, to June 2nd, 1920.

that I last saw him alive on June 2, 1920.

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Double)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

4/19/20 (Address) 408 S. Pratt Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D43701

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2020 Bank St. ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2020 Bank St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Inf* 4-COLOR OF RACE. *White* 5-SINGLE MARRIED WIDOWER OR DIVORCED (Write the word.) *Inf*6-DATE OF BIRTH, *May 25, 1920*
(Month) (Day) (Year)7-AGE, *5* yrs. mos. ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Infant*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Joseph Basculap*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*12-MAIDEN NAME OF MOTHER *May Ann*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph Basculap*(Address) *2020 Bank St.*

15-

JUN 2 - 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 2, 1920*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 25, 1920*, to *June 2, 1920*, that I saw him alive on *June 1, 1920*, and that death occurred, on the date stated above, at *10 a.* m.

The CAUSE OF DEATH* was as follows:

Pneumonia - 7 months
(Duration) yrs. mos. ds.CONTRIBUTORY *cause unknown*
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Joseph L. Volante* M. D.*June 2, 1920* (Address) *16 So. Bay*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St Vincent**June 3 1920*

20-UNDERTAKER

ADDRESS

*Wendell Duffel**375 Wm*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43705

D43705

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 Notre Dame Lane 27 WARD)

2-FULL NAME

Alfred Charles Barker

(a) RESIDENCE. NO. 403 Notre Dame Lane

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 4 mos.

How long in U. S., if of foreign birth? 6 yrs. 4 mos.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Grace L. Barker

6 DATE OF BIRTH (month, day, and year) May 5 - 1869

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Display Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

Heckscheld & Kohn

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

London England

10 NAME OF FATHER

Alfred Barker

11 BIRTHPLACE OF FATHER (city or town) (State or country)

England

12 MAIDEN NAME OF MOTHER

Alice Jacquelin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

14

Informant

(Address)

Grace L. Barker 403 Notre Dame Lane

15

Filed

19

Registrar

JUN 2 - 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1920

17

I HEREBY CERTIFY, That I attended deceased from

5/20, 1920, to 6/2, 1920,

that I last saw him alive on 6/1, 1920,

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopy, Spec. Anal.

(Signed) George W. Hoff, M. D.

16/2, 1920 (Address) 2020 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Providence R.I.

June 3 1920

20 UNDERTAKER

ADDRESS

Wm. G. Tickner & Sons

24 P. Ave

de la Hault 2020 N. Charles St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Part statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

George Layer
HEALTH DEPARTMENT-CITY OF BALTIMORE

D43706

CERTIFICATE OF DEATH.

92 D43706

PLACE OF DEATH

CITY OF BALTIMORE (No. 1714 Mc Carbur St. 14

WARD)

2-FULL NAME

George Layer

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1714 Mc Carbur

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, Col. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, (Month) (Day) (Year)

7-AGE, 58 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Labourer (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Md

10-NAME OF FATHER, James Layer

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Don't know

13-BIRTHPLACE OF MOTHER (State or Country), Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Wagoner Layer

(Address) 1714 Mc Carbur St.

15- ROBERT R. KRAUTER

JUN 3 - 1920

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jun 1, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I am in charge of the remains described above, held as (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

opsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Jones, M. D. (Coroner.)

6-2, 10120 (Address) E. Jones

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, National Unity

DATE OF BURIAL, Jun 2, 1920

20-UNDERTAKER, John B. Jones

ADDRESS, 538 Duffin St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43707

CERTIFICATE OF DEATH.

D43707

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

3633 Reisterstown Rd.

WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Michael Burne

(Residence in Baltimore: No.

3633 Reisterstown Rd.

St.; 45 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Widowed

6-DATE OF BIRTH,

July 15, 1854

7-AGE,

65 yrs., 10 mos., 17 ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, business, or establishment in which
employed (or employer).Hatter
Retired9-BIRTHPLACE,
(State or Country),

Ireland

PARENTS.

10-NAME OF
FATHER,

Thomas Burne

11-BIRTHPLACE
OF FATHER
(State or Country)

Ireland

12-MAIDEN NAME
OF MOTHER

Bunnis Common

13-BIRTHPLACE
OF MOTHER
(State or Country)

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John A. Paeder

(Address)

3633 Reisterstown Rd.

15-

JUN 3 - 1920

ROBERT E. KRAUTER

Filed

191

Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 2, 1920

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from
Feb 1920, to June 1920,
that I saw him alive on May 29, 1920,
and that death occurred, on the date stated above, at 7:30 PM

The CAUSE OF DEATH* was as follows:

Convulsions
Been paralysed
since Feb 18, 1920

(Duration).... yrs.... mos.... ds.

CONTRIBUTORY
(Secondary)

(Duration).... yrs.... mos.... ds.

(Signed) J. J. Termerhough M. D.

6/2, 1920 (Address) 3528 Park Heights

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs.... mos.... ds. In the State.... yrs.... mos.... ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL.

New Cathedral

DATE OF BURIAL,

June 4, 1920

20-UNDERTAKER

William Cool

ADDRESS

502 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43708

CERTIFICATE OF DEATH.

150 D43708
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 Gutterman av ST. 9 WARD)

2-FULL NAME

(Residence in Baltimore: No. 619 Gutterman av St.;yrs.,mos. 5 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single
(Write the word.)6-DATE OF BIRTH, May 28, 1920
(Month) (Day) (Year)7-AGE,yrs.,mos. 5 ds. If LESS than 1 day,hrs. ormin.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Baltimore Mo10-NAME OF FATHER, Wm J. Armiger11-BIRTHPLACE OF FATHER (State or Country), Baltimore Mo12-MAIDEN NAME OF MOTHER Barbara E Cook13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Mo

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm J. Armiger(Address) 619 Gutterman av

15-

Filed JUN 3 - 1920

ROBERT B KRAUTER

Burial Perm NOTED

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 2, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 28 1920, to June 2 1920, that I saw him alive on June 1 1920, and that death occurred, on the date stated above, at 6 P. m.The CAUSE OF DEATH* was as follows:
Spina Bifida(Duration).....yrs.....mos. 5 ds.CONTRIBUTORY.....infectious
(Secondary)(Duration).....yrs.....mos. 9 ds.(Signed) Joseph E. Hagan M. D.June 3, 1920 (Address) 1520 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. 5 ds. In the State.....yrs.....mos. 5 ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cedar Hill Cem June 3, 192020-UNDERTAKER ADDRESS 1039E. Schloman Lawson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43709

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43709

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hosp.* ST.: *4* WARD)

2-FULL NAME

(a) RESIDENCE. No. *3808 Finchurch* ST., WARD. *New York*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *10*

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

C. S. Emmerson

6 DATE OF BIRTH (month, day, and year)

June 1870

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

50

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind.

10 NAME OF FATHER

Fred. C. Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Penn.

12 MAIDEN NAME OF MOTHER

Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind.

14

Informant (Address)

C. S. Emmerson 3808 Finchurch St.

15

JUN 3 - 1920

ROBERT A. KAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6/2 1920

17

I HEREBY CERTIFY, That I attended deceased from

6/1 1920, to *6/2 1920*

that I last saw him alive on *6/2 1920*

and that death occurred, on the date stated above, at *4:30 a. m.*

The CAUSE OF DEATH* was as follows:

atrophic arthritis of spine

(duration) *1* yrs. *10* mos. *15* ds.

CONTRIBUTORY (Secondary)

Tetanus

(duration) *15* yrs. *10* mos. *15* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *6/1/20*

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Louis C. Ridgeley* M. D.

6/2 1920 (Address) *Mary Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Grind Ridge Cem

May 4 1920

20 UNDERTAKER

Henry Jenkins, Towson, Md.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3422 Chestnut St 13 WARD)

2-FULL NAME

George H Bull

(a) RESIDENCE. NO.

3422 Chestnut St 13 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofMartha M Bull6 DATE OF BIRTH (month, day, and year) Nov 14 18437 AGE 76 Years 6 Months 18 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

St Mills

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

PARENTS

14 Informant (Address) Mr M Burns
3422 Chestnut St

15

JUN 3 - 1920ROBERT A KRAUTER
RegistrarBurial Permit 0122

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 19 2017 I HEREBY CERTIFY, That I attended deceased from March 1, 19 20, to June 2, 19 20that I last saw him alive on June 2, 19 20and that death occurred, on the date stated above, at 245 P.

The CAUSE OF DEATH was as follows:

apoplexy

CONTRIBUTORY

Chronic Interstitial Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Chemical Micro.(Signed) Chas. W. 365 W. 36th St. M. D.

6/3, 1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Marys Hampton June 3 1920

20 UNDERTAKER

ADDRESS

Chenoweth Long Chestnut

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43711

CERTIFICATE OF DEATH.

79 D43711

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 Light St ST. 24 WARD)

2-FULL NAME Dorothea R. Falk

(a) RESIDENCE. No. 1825 Light St ST. 24 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth 50 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 29, 1844

7 AGE Years 76 Months 9 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Charles Falk (Address) 1825 Light St.

15 JUN 3 - 1920 ROBERT A. FAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1920

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1920 to June 1, 1920 that I last saw her alive on May 31, 1920 and that death occurred, on the date stated above, at 2 a. m. The CAUSE OF DEATH* was as follows:

Arterio Insufficiency

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted at place of death If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Harry Heibel 6/3, 1920 (Address) 1274 Hanover St Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Cross A. A. 6/4 1920

20 UNDERTAKER ADDRESS

Mrs. E. Evans 1428 St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43712

CERTIFICATE OF DEATH.

45 D43712

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital.ST. 10

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Odenhal(a) RESIDENCE. No. 930 E. Biddle St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1869

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.51

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workPlumber(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.10 NAME OF FATHER Henry Odenhal11 BIRTHPLACE OF FATHER (city or town) Baltimore,
(State or country) Md.12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Md.14 Informant Hospital Record(Address) New City Hospital.15 Filed JUN 3 - 1920 ROBERT E. KAUTER
Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1920

17

I HEREBY CERTIFY, That I attended deceased from
May 10, 1920 to June 1, 1920
that I last saw him alive on June 1, 1920
and that death occurred, on the date stated above, at 2:00 P.m.

The CAUSE OF DEATH* was as follows:

Aortic aneurysm
AneurysmCONTRIBUTORY (duration) yrs. mos. ds.
Latent sinus throm-
bosis (duration) yrs. mos. ds.18 Where was disease contracted unknown
if not at place of death?Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis?
(Signed) Frank T. Barker, M. D.June 1, 1920 (Address) New City Hospital.*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral
UNDERTAKERJune 5, 1920E. F. WiedefeldFuneral Home

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43713

CERTIFICATE OF DEATH.

79 D43713

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2763 Tivoly Ave.* ST. *9* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *2763 Tivoly* ST. *9* WARD. (If nonresident give city or town and State)Length of residence in city or town where death occurred *47* yrs. mos. ds. How long in U. S., if of foreign birth? *47* yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Julia Schweitzer*6 DATE OF BIRTH (month, day, and year) *Jan 31 - 57*7 AGE Years *63* Months *4* Days *2* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

PARENTS

14 Informant (Address) *Julia Schweitzer 2763 Tivoly Ave*

15

Filed

19

JUN 3 - 1920

ROBERT E. BRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 2, 1920*17 I HEREBY CERTIFY, That I attended deceased from *May 26, 1920* to *June 2, 1920*that I last saw him alive on *May 31, 1920*and that death occurred, on the date stated above, at *1 A. M.*

The CAUSE OF DEATH* was as follows:

Organic Heart Disease(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) *2* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*What test confirmed diagnosis? *Physic. Ex.*(Signed) *J. S. & Kinsler* M. D.6/3, 1920 (Address) *2700 Harford Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Lorraine Leem**June 5, 1920*

20 UNDERTAKER

ADDRESS

*Philip Herwig**2016 Orleans*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2411 N. North ave ST.; 15 WARD)

2-FULL NAME

Robert N. Dorey(Residence in Baltimore: No. 2411 N. North ave St.; 72 yrs., 8 mos., 18 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

Sept 14, 1887
(Month) (Day) (Year)

7-AGE,

32 yrs., 8 mos., 18 ds.If LESS than 1 day,
....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Retired9-BIRTHPLACE,
(State or Country).Maryland

10-NAME OF FATHER,

Robt N. Dorey11-BIRTHPLACE OF FATHER
(State or Country)Don't know

12-MAIDEN NAME OF MOTHER

M. McLean13-BIRTHPLACE OF MOTHER
(State or Country)Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard B. Shuler(Address) 2411 N. North ave

15-

JUN 3 - 1920 ROBERT E. KAUTER
Filed.....191.....BRIAN FARM

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 1st, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 1, 1920, to June 1, 1920,
that I saw him alive on May 31, 1920,
and that death occurred, on the date stated above, at 2 P. m.The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis.....
..........
.......... (Duration) 2 yrs., 8 mos., 18 ds.CONTRIBUTORY
(Secondary)..... (Duration) 2 yrs., 8 mos., 18 ds.(Signed) June E. Shuler, M. D.June 1, 1920 (Address) 712 N. N. Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.mos.ds. Is the State.....yrs.mos.ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

June 4th, 1920

20-UNDERTAKER

Geo. B. B. & Son 2503 E. Lombard Ave

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19-H. P. Co. 1000 Bks.

D43715

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3306 Pallant ST. 12 WARD)

2-FULL NAME

(a) RESIDENCE. No. 3306 Pallant ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of

6 DATE OF BIRTH (month, day, and year) Jan 20 1871

7 AGE

49

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Orsaph Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14

Informant (Address) 3306 Pallant St

15

JUN 3 - 1920

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1920

17

HEREBY CERTIFY, That I attended deceased from May 26 1920, to May 31 1920, that I last saw her alive on May 31 1920, and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

CONTRIBUTORY (Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Smith, M. D.

(Address) 1524 U. H. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel county

June 3 1920

20 UNDERTAKER

Mrs Robert A. Elliott, Oakland

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43716

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43716

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Wife are near Stanford St.* ST. WARD)

2-FULL NAME *Phillip P. Heins*

(Residence in Baltimore: No. *3 Schaffer Ave Hamilton* St.: yrs. *1* mos. *1* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*

4-COLOR OR RACE, *W*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)

6-DATE OF BIRTH, *March 8, 1852*

(Month)

(Day)

(Year)

7-AGE, *68*

YRS. *2*

MON. *23*

DS. *23*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Clerk*

(b) General nature of industry, business, or establishment in which employed (or employer), *Label Printers*

9-BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *Henry Heins*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER, *Annie Baltz*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Christina Heins*

(Address), *3 Schaffer Ave Hamilton*

15-

JUN 3 - 1920

ROBERT B. KRAUTER

Barial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 1, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

the body and from the evidence obtained by said inquest, autopsy or inquiry.

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. H. Bailey* M. D.

1-8-20 (Address) *1-8-20*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cemetery*

DATE OF BURIAL, *June 4, 1920*

20-UNDERTAKER, *Frank Lassam*

ADDRESS, *Hamilton Md*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.43717

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.43717

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) University Hospital ST. 4 WARD

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victor Gachkowske

(a) RESIDENCE. NO. Star City W. Va. ST. WARD. (Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE Years 42 Months — Days — If LESS than day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work miner (b) General nature of industry, business, or establishment in which employed (or employer) Coal Miner (c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Joseph Gachkowske

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Rose Sabat

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant University Hospital (Address)

15 Filed Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-31-1920

17 I HEREBY CERTIFY, That I attended deceased from 4-17-1920 to 5-31-1920, that I last saw him alive on 5-31-1920, and that death occurred, on the date stated above, at 12:40 m. The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds. CONTRIBUTORY (Secondary) Older of lungs (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & X-ray

(Signed) Wm. Allen M. D. 5/31, 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

UNIVERSITY OF MARYLAND

JUN 3 - 1920

20 UNDERTAKER

Commissioner Health

JUN 8 - 1920

Burial Permit

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43718

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, Male
4-COLOR OR RACE, Colored
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, August 10, 1899
(Month) (Day) (Year)

7-AGE, 21 yrs. 9 mos. 21 ds.
If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Butler
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), West Virginia

10-NAME OF FATHER, James Newman

11-BIRTHPLACE OF FATHER (State or Country), D.C.

12-MAIDEN NAME OF MOTHER, Minnie Newman

13-BIRTHPLACE OF MOTHER (State or Country), D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Floral S. Newman

(Address), 1121 Myrtle Ave.

15- JUN 3.- 1920 ROBERT E. KAUTER

Filed, 191, BY THE REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Tuesday, June 1st, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 31st 1920, to June 1st 1920, that I saw him alive on June 1st 1920, and that death occurred, on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia (Double)
(Duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Exhaustion
(Duration) yrs. mos. 4 ds.
(Signed) E. J. H. Chavens
M. D.
607 E. Chavens St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Mt. Auburn Cemetery, June 4, 1920

20-UNDERTAKER, John M. Johnson, 1234 E. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43719

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

Kujawaski
Mary Kujawaski
Anna Kujawaski
2804 Hudson

REGISTERED NO. C.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. *35* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *Cuban* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *wid*

6-DATE OF BIRTH, 1
(Month) (Day) (Year)

7-AGE, *36* If LESS than 1 day, hrs. or min.?
..... yrs. mos. ds.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *worked in 1886*
(b) General nature of industry, business, or establishment in which employed (or employer) *Bundy factory*

9-BIRTHPLACE, (State or Country), *Poland*

PARENTS.
10-NAME OF FATHER, *Alexander Drapozyski*
11-BIRTHPLACE OF FATHER (State or Country), *Poland*
12-MAIDEN NAME OF MOTHER *Mary Wyzymanski*
13-BIRTHPLACE OF MOTHER (State or Country), *Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Alexander Drapozyski*
(Address) *2804 Hudson*

15-
Filed. JUN 3 - 1920 ROBERT A. KRAUTER
Burial Place *St. Stanislaus Cemetery*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *May 30, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract. Skull caused by being
accidentally struck by Elevator
(at Lauer & Dutess)
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) *Arthur* M. D.
(Coroner.)
June 2, 1920 (Address) *629 Bay*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place *2 days* In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Stanislaus Cemetery* DATE OF BURIAL, *June 4, 1920*
20-UNDERTAKER, *Stephen Trachowski* ADDRESS *1000 3rd Avenue*

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

D43720

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43720

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Maryland General Hosp. St.* ST. 15 WARD)

REGISTERED No. C

2-FULL NAME

Elinor Virginia Meeks

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *3402 Garrison Ave*)

St.; yrs. *5* mos. *23* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)

6-DATE OF BIRTH, *April 10, 1912* (Month) (Day) (Year)

7-AGE, *8 yrs. 1 mos. 23 ds.* If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Student* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) *Washington, D.C.*

10-NAME OF FATHER, *Rev. Benj. H. Meeks*

11-BIRTHPLACE OF FATHER (State or Country) *Balto. Co. Md.*

12-MAIDEN NAME OF MOTHER *Lillian Eva Meeks*

13-BIRTHPLACE OF MOTHER (State or Country) *Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Arthur C. Beall*

(Address) *1811 N. Lafayette St.*

15- *JUN 3 - 1920* *ROBERT B. KRAUTER*

Filed..... 191... *Baltimore* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 2, 1920* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

quesh find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

fractured skull

(Duration)..... yrs..... mos. *14* ds.

CONTRIBUTORY *Epidemic cerebro spinal meningitis* (Secondary) (Duration)..... yrs..... mos. *4* ds.

(Signed) *J. D. Hemmings* M. D. (Coroner.)

June 3, 1920 (Address) *3402 Garrison Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos. *12* ds. In the *Md. Gen. Hosp.* State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence *3402 Garrison Ave.*

19-PLACE OF BURIAL OR REMOVAL, *Forham Cemetery* DATE OF BURIAL, *June 8, 1920*

20-UNDERTAKER, *Geo. J. Smith* ADDRESS *1000 N. Fayette St.*

Physicians should state cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 372 T. Morris St.)

ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE

(Usual place of abode)

ST.: 5 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE Years 48 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER Mulcrum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mulcrum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14

Informant (Address) Oliver Bree 372 T. Morris St.

15

Filed JUN 3 - 1920 ROBERT B. KEAULTER Burial Permit 0191

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1920

17

I HEREBY CERTIFY, That I attended deceased from May 29, 1920, to June 1, 1920, that I last saw him alive on June 1, 1920, and that death occurred, on the date stated above, at 11 A. M. The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green M. D.

6-1, 1920 (Address) 120 1/2 Disgrace St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stephen's June 3 1920

20 UNDERTAKER

ADDRESS

Charles B. Jones 2115 R. Pine

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43722

D43722

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *502 Hunsem* ST.: *17* WARD)

2-FULL NAME *Alberta Gross*

(Residence in Baltimore: No. *502 Hunsem* St.; yrs., *40* mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *female*

4-COLOR OR RACE, *colored*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married*
(Write the word.)

6-DATE OF BIRTH, *Feb. 23, 1880*
(Month) (Day) (Year)

7-AGE, *40 yrs. 2 mos. 9 ds.*

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Home Duties*
(b) General nature of industry, business, or establishment in which employed (or employer), *037*

9-BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *Isaac T. Brotten*

11-BIRTHPLACE OF FATHER (State or Country), *Maryland*

12-MAIDEN NAME OF MOTHER, *Emma Miller*

13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George Merritt*

(Address) *505 Dolphin St.*

15-

Filed *JUN 3 - 1920* ROBERT A. LAUTER

Burial Permit No. *6666*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 2, 1920*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry*
(Inquest, autopsy or inquiry.)

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. *6* mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. D. Hemmery* M. D.
(Coroner.)

June 3, 1920 (Address) *2807 Edgewood Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *St. Ignace*

DATE OF BURIAL, *June 4, 1920*

20-UNDERTAKER

Charles B. Jones

ADDRESS

211 Pine St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43723

CERTIFICATE OF DEATH.

152 D43723
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 740 W Redwood ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Baby Carter

(Residence in Baltimore: No. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Male</u>	4-COLOR OR RACE, <u>Colored</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <u>Single</u>
-----------------------	------------------------------------	--

6-DATE OF BIRTH, <u>May</u> <u>31</u> , <u>1920</u> (Month) (Day) (Year)
--

7-AGE, yrs. mos. ds.	If LESS than 1 day, <u>2</u> hrs. or min.?
---	--

8-OCCUPATION: (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer).....	<u>None</u>
--	-------------

9-BIRTHPLACE, (State or Country), <u>Baltimore Md</u>

PARENTS.	10-NAME OF FATHER, <u>James Carter</u>
	11-BIRTHPLACE OF FATHER (State or Country), <u>Annapolis Md</u>
	12-MAIDEN NAME OF MOTHER <u>Clara Smith</u>
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Virginia</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Carter
(Address) 740 W Redwood St15-JUN 8 - 1920 Robert P. Harrison,
101
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,
June 2, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
May 31, 1920, to June 2, 1920,
that I saw him alive on June 1, 1920,
and that death occurred, on the date stated above, at 5:24 m.
The CAUSE OF DEATH* was as follows:Congenital Atelectasis
(Duration)..... yrs. mos. ds.CONTRIBUTORY.....
(Secondary)(Duration)..... yrs. mos. ds.
(Signed) R. C. Delez M. D.
June 7, 1920 (Address) Merin Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Ann's Cemetery, 1920. DATE OF BURIAL,20-UNDERTAKER, Mrs. Scott Hoyer ADDRESS 406 W. Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9 H. P. Co. 1000 Bks.

043721 HEALTH DEPARTMENT—CITY OF BALTIMORE 043721

CERTIFICATE OF DEATH.

1-PLACE OF DEATH.

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Louis Kaufman*

(a) RESIDENCE. No. *19 Reed St. Pittsburgh Pa.* WARD. *Pittsburgh Pa.*
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *17* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Single</i>
6a If married, widowed, or divorced HUSBAND of (or) WIFE of <i>Single</i>		
6 DATE OF BIRTH (month, day, and year) <i>Feb 24 1894</i>		
7 AGE <i>26</i> Years <i>4</i> Months <i>9</i> Days	LESS than 1 day, hrs. or min.	
8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work <i>Salesman</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>066</i> (c) Name of employer		
9 BIRTHPLACE (city or town) (State or country) <i>Russia</i>		
10 NAME OF FATHER <i>2</i>		
11 BIRTHPLACE OF FATHER (city or town) (State or country) <i>2</i>		
12 MAIDEN NAME OF MOTHER <i>2</i>		
13 BIRTHPLACE OF MOTHER (city or town) (State or country) <i>2</i>		
14 Informant <i>Hospital Record</i> (Address) <i>21 St.</i>		
15 Filed <i>Robert P. Harrison,</i> <i>JUN 8 - 1920</i> Registrar		

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 2 1920*

17 I HEREBY CERTIFY, That I attended deceased from *May 16, 1920*, to *June 2, 1920*, that I last saw him live on *June 2, 1920*, and that death occurred, on the date stated above, at *5:20 p.m.* The CAUSE OF DEATH* was as follows:
Brain tumor

(duration) *1* yrs. *✓* mos. *—* ds.

CONTRIBUTORY (Secondary) (duration) *✓* yrs. *—* mos. *—* ds.

18 Where was disease contracted if not at place of death? *Cos home*
Did an operation precede death? *yes* Date of *May 20, 1920*
Was there an autopsy? *no*

What test confirmed diagnosis?
(Signed) *Wm R. Reid* M. D.
. 19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Pittsburgh, Pa.* DATE OF BURIAL *June 3 1920*

20 UNDERTAKER *William G. Schaeffer* ADDRESS *1816 Mount*

D43725

HEALTH DEPARTMENT—CITY OF BALTIMORE

82 ✓ D43725

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2231 Preston Place WARD) 8

2-FULL NAME

(Residence in Baltimore: No. 2231 Preston Place St. 60 yrs., 60 mos., 60 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

WidowOR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

Dec 25,

(Month)

(Day)

(Year)

7-AGE,

70

yrs.

5

mos.

10

ds.

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none9-BIRTHPLACE,
(State or Country),England

PARENTS.

10-NAME OF FATHER,

Thomas Tygh11-BIRTHPLACE OF FATHER
(State or Country),England

12-MAIDEN NAME OF MOTHER

not known13-BIRTHPLACE OF MOTHER
(State or Country),England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

James E. Clark

(Address)

806 W. Baltimore St.

15-

Robert P. Harrison,

101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 3,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 3, 1920, to June 3, 1920,that I saw her alive on June 2, 1920and that death occurred, on the date stated above, at 7²³ A m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Edw. C. Eisinger, M. D.June 3, 1920 (Address) 2241 Oglethorpe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Cathedral Cemetery June 5, 1920

20-UNDERTAKER:

ADDRESS

Margaret E. Flynn 1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

JUN 3 1920

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

143726

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST.: 0 WARD

2-FULL NAME

(a) RESIDENCE. NO. 1124 N. Broadway ST. ✓ WARD ✓

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 2 yrs. 0 mos. 0 ds.

MEDICAL CERTIFICATE OF DEATH

3 SEX M	4 COLOR OR RACE W	5 Single, Married, Widowed, or Divorced (write the word)
------------	----------------------	---

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of *Mary M. Johnson*

6 DATE OF BIRTH (month, day, and year) 14/11/1846

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	75		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) 1

14 Informant Mauro M. Anderson
(Address) 13311 11th Street

15 Filed 1900 Robert P. Harrison Registrar

16 DATE OF DEATH (month, day, and year) June 3 1964

17
I HEREBY CERTIFY That I attended deceased from
May 30 1925, to June 2 1925.

that I last saw him live on July 2, 1950,
and that death occurred, on the date stated above, at 12451 m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 11-1-68

Was there an autopsy?

What test confirmed diagnosis?

(Signed) _____ M. D. _____

, 19 (Address) 1503 8th Ave S

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL.

20 UNDERTAKER

ADDRESS

Funeral Permit Clerk.

JUN 3 - 1920

D43727

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43727

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 S. Smallwood ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander M. Waterworth(a) RESIDENCE. NO. 318 S. Smallwood ST. 20 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow6 DATE OF BIRTH (month, day, and year) Aug 2/18407 AGE 79 Years 9 Months 9 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Samuel Waterworth11 BIRTHPLACE OF FATHER (city or town) Chelmsford (State or country)12 MAIDEN NAME OF MOTHER Jane Waterworth13 BIRTHPLACE OF MOTHER (city or town) Chelmsford (State or country)14 Informant George Waterworth (Address) 1922 S. Main

15 JUN 3 - 1920 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 192017 I HEREBY CERTIFY, That I attended deceased from May 23, 1920, to June 2, 1920, that I last saw him alive on June 3, 1920, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Edema of LungsCONTRIBUTORY (duration) yrs. mos. ds. Chronic interstitial nephritis(Secondary) (duration) yrs. mos. ds. Insomnia

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? autopsy (Signed) Wm. Cook, M. D.63, 1920 (Address) 54 S. Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London, Md.

20 UNDERTAKER

Wm. Cook

ADDRESS

54 S. Fulton

Burial Permit Clerk.

Information should be carefully supplied. AGE should be stated EXACTLY. For signature of informant, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully reported. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43728

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Dr. Fair
254 W. Chase
90 D43728

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 E. 31st St. ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Eliza Miller

(a) RESIDENCE. NO. 401 E. 31st ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 13 1888

7 AGE Years 81 Months 6 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) job

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER John F. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Sprigg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Alice F. Miller (Address) 401 E. 31st St.

15 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1920

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1920, to June 2, 1920, that I last saw her alive on June 1, 1920, and that death occurred, on the date stated above, at 12-30 a.m. The CAUSE OF DEATH* was as follows:

Chronic Bronchitis (duration) 2 yrs. mos. 7 ds. CONTRIBUTORY Cardiac Insufficiency (Secondary) (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Did an operation precede death? No Date of Was there an autopsy? No What test confirmed diagnosis? M. A. Fair (Signed) 4/3, 1920 Address) 12 E 25th St. M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43729

D43729

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 N. Durham St.; 8 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1717 N. Durham St.; Life mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

June 11 1917, 1 (Month) (Year)

7-AGE,

3 yrs. 5 mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Child.

9-BIRTHPLACE, (State or Country),

Ind.

10-NAME OF FATHER,

Charles W. Knight

11-BIRTHPLACE OF FATHER (State or Country),

Ind.

12-MAIDEN NAME OF MOTHER

Maudie Maguire

13-BIRTHPLACE OF MOTHER (State or Country),

Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles W. Knight

(Address) 1717 N. Durham St.

15-

Robert P. Harrison,

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 3, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 24 1920, to June 3 1920,

that I saw her alive on June 3 1920,

and that death occurred, on the date stated above, at 5:15 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Jacob Fisher, M. D.

June 3, 1920 (Address) 1823 N. Rust St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Balto Cemetery

DATE OF BURIAL,

20-UNDERTAKER

William Cook

ADDRESS

5025 North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 3 - 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43730

151/143730

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2023 E. - 31 ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2023 E. - 31 St. yrs. mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)

6-DATE OF BIRTH, *May 25, 1920*
(Month) (Day) (Year)

7-AGE, *7* yrs. mos. ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *None*
(b) General nature of industry, business, or establishment in which employed (or employer), *None*

9-BIRTHPLACE, (State or Country), *Balt. Md.*

10-NAME OF FATHER, *Leroy N. Riley*
11-BIRTHPLACE OF FATHER (State or Country), *Balt. Md.*
12-MAIDEN NAME OF MOTHER, *Irene Riley*
13-BIRTHPLACE OF MOTHER (State or Country), *Balt. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Leroy N. Riley*(Address) *2023 E. - 31st St.*

15- Robert P. Harrison,

JUN 5 1920 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 3, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 25, 1920*, to *June 3, 1920*, that I saw him alive on *June 2, 1920*, and that death occurred, on the date stated above, at *4 A.* m. The CAUSE OF DEATH* was as follows:

Septic neonatal
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Infection*
(Duration) yrs. mos. ds.
(Signed) *Robert P. Harrison* M. D.
June 3, 1920 (Address) *1318 P. Charles St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cedar Hill* DATE OF BURIAL, *June 4, 1920*

20-UNDERTAKER, *Leo G. Brock* ADDRESS, *North Charles St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43731

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 n. Poppleton ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 407 n. Poppleton St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Caucasian

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

Dec 8, 1916
(Month) (Day) (Year)

7-AGE,

3 yrs., 5 mos., ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Teacher

9-BIRTHPLACE, (State or Country).

407 n. Poppleton

10-NAME OF FATHER,

Rev R.T. Wiem

11-BIRTHPLACE OF FATHER

Va

12-MAIDEN NAME OF MOTHER

Margt. Gooder

13-BIRTHPLACE OF MOTHER (State or Country),

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

R.T. Wiem

(Address)

407 n. Poppleton St.

15-

Filed JUN 4 - 1920

ROBERT B. KAUTER

BALTIMORE HEALTH DEPARTMENT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 3, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

June 2, 1920, to June 3, 1920,

that I saw her alive on June 2, 1920,

and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Convulsions

(Duration) ... yrs. ... mos. ... ds.

(Signed)

P.H. Casey M.D.

1920 (Address) 500 n. Fremont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

DATE OF BURIAL,

June 4, 1920

20-UNDERTAKER

Joseph A. Farrell

ADDRESS

1217 Division

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43732

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 Saraband ST.; 4 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 612 Saraband St.; 2 yrs., 2 mos., 2 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Black5-SINGLE, Married,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

Apr 3, 1918
(Month) (Day) (Year)

7-AGE.

2 yrs., 2 mos., 2 ds.
If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, business,
or establishment in which
employed (or employer).....9-BIRTHPLACE,
(State or Country),10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country),12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Jackson(Address) 612 Saraband

15-

Filed JUN 4 - 1920

ROBERT E. KRAUTER

BAPTIST CHURCH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 3, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 20, 1918, to June 3, 1920,
that I saw him alive on June 3, 1920,
and that death occurred, on the date stated above, at 11:10 m.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) 4 yrs., 4 mos., 4 ds.CONTRIBUTORY
(Secondary)Asphyxia
(Duration) 1 yrs., 1 mos., 1 ds.
(Signed) J. H. Martin M. D.
612 Saraband (Address) 424 H. Street*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs., 2 mos., 2 ds. In the State 2 yrs., 2 mos., 2 ds.Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Paul's Church June 3, 1920

20-UNDERTAKER

ADDRESS

Charles D. Jones 211 Pine St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital* 18 WARD)
CITY OF BALTIMORE: (No. *University Hospital* ST. *18* WARD)
2-FULL NAME *Harry H. Beach*
(a) RESIDENCE. NO. *107 S. Arlington Ave. Balto Md.* ST. *18* WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. *37*
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec. 26, 1896*

7 AGE Years *23* Months *5* Days *8* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Mariner*
(b) General nature of industry, business, or establishment in which employed (or employer) *686*
(c) Name of employer

9 BIRTHPLACE (city or town) *Balti, more Md.* (State or country)

10 NAME OF FATHER *Harry Beach*

11 BIRTHPLACE OF FATHER (city or town) *Md.* (State or country)

12 MAIDEN NAME OF MOTHER *B. Miller*

13 BIRTHPLACE OF MOTHER (city or town) *Md.* (State or country)

14 Informant *Hospital Records* (Address)

15 Filed *JUN 4 - 1920* REGISTRAR *ROBERT E. KRAUTER* (Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 3 1920*

17 I HEREBY CERTIFY, That I attended deceased from *May 10*, 19 *20*, to *June 3*, 19 *20*, that I last saw him alive on *June 3*, 19 *20*, and that death occurred, on the date stated above, at *5.15 a.m.*

The CAUSE OF DEATH* was as follows:

Aneurysm - Abdominal Aorta

not known (duration) yrs. mos. ds.
CONTRIBUTORY *Hemorrhage* (Secondary) *few hours* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *no*

Was there an autopsy? *no*

What test confirmed diagnosis? *Physical signs*

(Signed) *Ralph E. Duncan* M. D.

, 19 (Address) *723 S. Paul, Balto*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Mary's Hampton Inn 19 *20*

20 UNDERTAKER ADDRESS

John Stiles 1200 W. Lombard

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

043734

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 733 School ST. 15 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 733 School ST. 15 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female Colored Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

July 21, 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

10

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

James Bond

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Ella Smalchen

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

James Bond 733 School St

15

Filed

JUN 4 - 1920

ROBERT E. ERAUTER Registrar

Barial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 2, 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 21, 1920, to June 2, 1920,

that I last saw him alive on June 1, 1920,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastric Enteritis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

No

No

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

No

(Signed)

William Frey, M. D.

6/2, 1920

Address) 1928 Pa. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Not buried

June 4, 1920

20 UNDERTAKER

R. L. Parnham

ADDRESS

131 N. Delany

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43735

90 D43735

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1517 W Fayette* St.; *19* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1517 W. Fayette* St.; *60* yrs., mos., ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Female

4-COLOR OR RACE

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *widow*

6-DATE OF BIRTH

April 6, 1846
(Month) (Day) (Year)

7-AGE

74 yrs., *1* mos., *28* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Home*

9-BIRTHPLACE, (State or Country),

Md

10-NAME OF FATHER,

James G. Clay

11-BIRTHPLACE OF FATHER (State or Country),

N. H.

12-MAIDEN NAME OF MOTHER

Mary Hitchcock

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Miss Amelia Kemner*(Address) *1517 W. Fayette St.*

15-

JUN 4 - 1920

Filed

191

ROBERT B. KRAUTER

BURIAL PERMIT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 2, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*March 1, 1920, to June 2, 1920*that I saw her alive on *June 2, 1920*,and that death occurred, on the date stated above, at *10 P.* m.

The CAUSE OF DEATH* was as follows:

Injured Hip - Chr. Bronchitis(Duration) *2* yrs., mos., ds.CONTRIBUTORY *Paralysis* (Secondary)(Duration) *4* yrs., mos., ds.(Signed) *Edwin Murray* M. D.*June 4, 1920* (Address) *1221 W. Fayette St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the yrs., mos., ds. State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Lorraine Cemetery

DATE OF BURIAL,

May 25, 1920

20-UNDERTAKER

Chas. E. Branch

ADDRESS

802 Madison Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43736

CERTIFICATE OF DEATH.

81 D43736
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *242 Wilson*)ST. *14* WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *242 Wilson St*)St. *80* yrs., *0* mos. *19* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED, *Married*
WIDOWED,
OR DIVORCED;
(Write the word.)

6-DATE OF BIRTH,

May 15, 1840
(Month) (Day) (Year)

7-AGE,

80 yrs. 0 mos. 19 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*None*9-BIRTHPLACE,
(State or Country),*Baltimore*

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

JUN 4 - 1920

ROBERT R. KRAUTER

Filed..... 191..... *Bureau of Health* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 3, 1920
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *May 30 1920* to *June 3 1920*, that I saw him alive on *June 3 1920*, and that death occurred, on the date stated above, at *11:30 A.M.*

The CAUSE OF DEATH* was as follows:

Acute Congestion of Kidneys with Suppression of Urine

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *A. C. Poli* M. D.*June 3, 1920* (Address) *2034 Madison St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Green Mount Cemetery *June 4, 1920*20-UNDERTAKER
STEWART & MOWEN COMPANY
WILLIAM F. WOODEN, Successor

ADDRESS

108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43737

CERTIFICATE OF DEATH.

170 D43737
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1053 W. Lexington ST.: 18 WARD)

2-FULL NAME Robert Pea

(Residence in Baltimore: No. 1053 W. Lexington

St.: 50 yrs., mos. ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Widowed

6-DATE OF BIRTH, not obtained, 1

(Month)

(Day)

(Year)

7-AGE, 74

yrs.

mos.

da.

If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, None

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Howard County, Md.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (State or Country) Howard County, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) 701 N. Carrollton Ln.

15-

Filed

JUN 4 - 1920

ROBERT E. KAUTER

101

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 2nd, 1920

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from May 30th 1920 to June 2nd 1920,

that I saw him alive on June 2nd 1920,

and that death occurred, on the date stated above, at 9:05 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchial Asthma

(Duration) 2 yrs. mos. da.

(Signed) Howard Spelback, M.D.

June 3rd 1920 (Address) 701 N. Carrollton Ln.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Not Known

DATE OF BURIAL, June 5, 1920

20-UNDERTAKER, Kelly B. Pyle

ADDRESS, 1028 Carrollton

N. B.—Every item of information should be carefully supplied. AGE should be stated exactly. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43738

CERTIFICATE OF DEATH.

34 D43738 8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 Calhoun

ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John W Gross

(a) RESIDENCE. NO. 1319 Calhoun

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

39 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 1878

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tobacco 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind.

10 NAME OF FATHER

John Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind.

12 MAIDEN NAME OF MOTHER

Barbara Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind.

14

Informant (Address)

Rachel Cook 1319 Calhoun St

15

JUN 4 - 1920

ROBERT B. FRUTTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6/3 1920

17

I HEREBY CERTIFY, That I attended deceased from

4/1 1920, to 6/3 1920,

that I last saw him alive on 6/3 1920,

and that death occurred, on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of kidneys spine

(duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) B. R. Butler, M. D.

, 19 (Address) 2139 Dandridge St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel Cemetery June 6 1920

20 UNDERTAKER

ADDRESS

Harriet W. Wright 1361 Mary

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43739

CERTIFICATE OF DEATH.

D43739

1-PLACE OF DEATH At Sea, on board
CITY OF BALTIMORE (No. S. S. Bald Butte. ST. 25 WARD) REGISTERED No. C
2-FULL NAME Charles Smith. (C)
(Residence in Baltimore: No. San Blas, Panama. St.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, Colored. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single. (Write the word.)

6-DATE OF BIRTH, Do not know. 1 (Month) (Day) (Year)

7-AGE, 26 yrs. 11 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Deck hand. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), San Blas, Panama.

PARENTS. 10-NAME OF FATHER, Do not know. 11-BIRTHPLACE OF FATHER (State or Country), Do not know. 12-MAIDEN NAME OF MOTHER, Do not know. 13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Charles Volke 2nd officer. S. S. Bald Butte, lying at Inter Ocean oil dock. (Address) Warner's Point.

15- JUN 4 - 1920 ROBERT H. TRAUTER Filed 191. Burial Permit. Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1st, 1920, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above. The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signature) Otto M. Reinhardt M. D. June 3rd 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Asbury Evergreen Cem. DATE OF BURIAL, June 4, 1920. ADDRESS 115 Light St. 20-UNDERTAKER John F. Denny

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43740

CERTIFICATE OF DEATH.

REGISTERED NO. C

D43740

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1102 Russell* ST.; *21* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

George W. Hartman(Residence in Baltimore: No. *1102 Russell* St.; *33* yrs., *3* mos., *21* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED, *married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

February 12, 1887
(Month) (Day) (Year)

7-AGE,

33 yrs., *3* mos., *21* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*wood worker*
*on*9-BIRTHPLACE,
(State or Country),*Balto Md.*

10-NAME OF FATHER,

*Geo Hartman*11-BIRTHPLACE OF FATHER
(State or Country),*Balto Md.*

12-MAIDEN NAME OF MOTHER

*Catherine Hoffmann*13-BIRTHPLACE OF MOTHER
(State or Country),*Balto.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary C. Hartman*(Address) *1102 Russell St.*

15-JUN 4 - 1928

ROBERT B KRAUTER

Filed..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

6 *2* *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 31, 1918, to *June 2, 1920*,that I saw him alive on *June 2, 1920*,and that death occurred, on the date stated above, at *6:30 P.* m.

The CAUSE OF DEATH* was as follows:

Diffuse nephritis
History 6 weeks
(Duration) *6* yrs. *6* mos. *6* ds.CONTRIBUTORY
(Secondary)(Duration) *6* yrs. *6* mos. *6* ds.(Signed) *Dr. Bernard J. Levy* M. D.*6/3/20*, 191... (Address) *710 W. Lombard*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Cross Hosp. Md. *6/5/1920* 191...

20-UNDERTAKER

ADDRESS

John Howard & Son *ger Holmquist*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43741

1-PLACE OF DEATH

CITY OF BALTIMORE, No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)6-DATE OF BIRTH, December 28, 1917 (Month) (Day) (Year)7-AGE, 2 yrs., 5 mos., 9 ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, Child (b) General nature of industry, business, or establishment in which employed (or employer), soo9-BIRTHPLACE, (State or Country), Baltimore, Md.10-NAME OF FATHER, Harry H. Stylock11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.12-MAIDEN NAME OF MOTHER, Edna May Weber13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Harry H. Stylock(Address), 706 N. Bond St.15- JUN 4 - 1920 ROBERT E. LAUTERFiled, 191 BY BYRNE PERKINS REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 3, 1920 (Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from May 23 1920 to June 3 1920, that I saw her alive on June 2 1920, and that death occurred, on the date stated above, at 6:30 A.M. The CAUSE OF DEATH* was as follows: measles

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pneumonia and Exhaustion

(Duration) ... yrs. ... mos. ... ds.

(Signed) Albert C. Grier M. D.(Address) 2127 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, OaklawnDATE OF BURIAL, June 5, 192020-UNDERTAKER, Girkler & GirklerADDRESS 1739 Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43742

CERTIFICATE OF DEATH.

64 D43742

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *242 N. Pine*)ST.: *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *William J. Polk*(a) RESIDENCE. NO. *242 N. Pine*

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *(Deceased)*6 DATE OF BIRTH (month, day, and year) *May-15-1833*7 AGE Years *87* Months *16* Days *16* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Carpenter* *OTIS*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Mrs. J. Polk*9 BIRTHPLACE (city or town) *Cruz de Gorgo* (State or country) *Ind*10 NAME OF FATHER *Wm. Polk*11 BIRTHPLACE OF FATHER (city or town) *Ind* (State or country)12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant *Mrs. Lena Paul* (Address) *242 N. Pine*15 *JUN 4 - 1920* *ROBERT E. LAUTER* Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 1* 19*20*17 I HEREBY CERTIFY, That I attended deceased from *May 8*, 19*20*, to *June 1*, 19*20*.that I last saw him alive on *June 1*, 19*20* and that death occurred, on the date stated above, at *5:40 a. m.*

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY *old age* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *No*What test confirmed diagnosis? *Physique* (Signed) *Edward J. Sheaffer*, M. D.*6/3 1920* (Address) *1230 David Bowie*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

National Cemetery *June 4 1920*

20 UNDERTAKER ADDRESS

Samuel S. Sausky *578 N. B.*

N. B.—WRITE CAREFULLY, WITH CAPS AND UNDERLINES—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

CERTIFICATE OF DEATH.

REGISTERED NO

ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. WARD

(a) RESIDENCE, NO. 219 Pine St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 19 20

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

17 I HEREBY CERTIFY, That I attended deceased from
May 27, 19 20 to June 2, 19 20
that I last saw her alive on June 1, 19 20
and that death occurred, on the date stated above, at 4:00 A.m.

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
36				

THE CAUSE OF DEATH* was as follows:

8 OCCUPATION OF DECEASED

(s) Trade, profession or particular kind of work	Housework
---	------------------

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records

Informant Hospital Records
(Address) New City Hospital

15 Filed JUN 4 - 1920 **ROBERT B. BRAUTER**
Registrar
Burial Permit Clerk

The CAUSE OF DEATH* was as follows:
Sacrospinally infected ulcers, leg
with cellulitis.

CONTRIBUTORY (Secondary) General Toxicemia subacute

18 Where was disease contracted if not at place of death? 219 Pine St

Did an operation precede death? yes Date of 1

Was there an autopsy?.....

What test confirmed diagnosis? _____
(Signed) Frank T. Barker, M. D.

June 2 1920 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
--	----------------

19 PLACE OF BURIAL, CREMATION, ETC. Mt. Auburn Cem. Nov 5 1922
ADDRESS

20 UNDERTAKER *Anna Dunsley* ADDRESS *58 Bldg*

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43745

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 Hawthorn Road

ST.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Adt

(a) RESIDENCE. No. 206 Hawthorn Road Roland Park

ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

82 yrs. 5 mos. 20 ds.

How long in U. S., if of foreign birth?

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

John B. Adt

6 DATE OF BIRTH (month, day, and year) Oct. 12, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER William Raine

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Fredericks

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Albert W. Adt

(Address) 300 East 30th St.

15 JUN 4 - 1920

ROBERT A. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 1920

17 I HEREBY CERTIFY, That I attended deceased from

for twenty years, to June 2, 1920,

that I last saw him alive on June 1, 1920,

and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(duration) 2 yrs. 5 mos. 20 ds.

CONTRIBUTORY Arteriosclerosis

(Secondary) (duration) 2 yrs. 5 mos. 20 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. C. R. Deegew, M. D.

, 19 (Address) 1702 E. 30th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Woodlawn Cemetery

DATE OF BURIAL

June 5, 1920

20 UNDERTAKER

Henry W. Mears & Son 805 N. Calvert

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43746

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1000 Riverside Ave* ST.: *24* WARD)2-FULL NAME *John Jos. Schuster Jr*(a) RESIDENCE. NO. *1000 Riverside Ave* ST.: *24* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *9*mos. *17*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Aug 16/1919*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Infant*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Batn Md*

10 NAME OF FATHER

John J. Schuster Jr

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Mrs E. Higgins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Balto Md*14 Informant
(Address)*John Jos. Schuster Jr
1000 Riverside Ave*

15 Filed

*JUN 4 - 1920*ROBERT E. KAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 2 1920*

17

I HEREBY CERTIFY, That I attended deceased from
May 19, 19*20*, to *June 2*, 19*20*,
that I last saw him alive on *June 2*, 19*20*,and that death occurred, on the date stated above, at *11:30* m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration)

yrs.

mos. *14*

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Physical
H. E. Stiller*

, M. D.

6/2/20 (Address)

*1319 High St**State the Disease Causing Death, in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Cross A.C.C.**6-4 1920*

20 UNDERTAKER

ADDRESS

*E and B Harle**115 E West St.*PHYSICIANS should be stated EXACTLY. Exact statement of OCCUR-
rence should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUR-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D43748

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D43748

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3221 Barclay

ST. 12 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 3221 Barclay

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 26 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Charles H Nash

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Ernestine Longenecker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Charles H Nash 3221 Barclay St

15

Filed JUN 4 - 1920

ROBERT E. ELAUTEH Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 2 1920

17

HEREBY CERTIFY, that I attended deceased from

May 31, 1920, to June 2, 1920,

that I last saw him alive on June 2, 1920,

and that death occurred, on the date stated above, at 9:00 m.

The CAUSE OF DEATH* was as follows:

Congestive debility
Pulmonary Interstitial

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. G. G. M. D.

Address 1534 - E. & Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Ctry

June 4 1920

20 UNDERTAKER

ADDRESS 725

Mrs Robt A Elliott

Arlington Ave

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43749

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43749

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 S. Linwood Ave ST. 1 WARD)

REGISTERED No. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha F Riddel

(a) RESIDENCE. No. 702 S. Linwood ST. 1 WARD. (Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb-14-20

7 AGE Years 3 Months 20 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Edward Riddel

11 BIRTHPLACE OF FATHER (city or town) Louisiana (State or country)

12 MAIDEN NAME OF MOTHER Catherine J. Riddel

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia (State or country) Pa

14 Informant Edward Riddel (Address) 100 S. Linwood Ave.

15 JUN 4 - 1920 ROBERT E. BRADY Registrar Burial Permit 01672

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 4 1920

17 I HEREBY CERTIFY, That I attended deceased from 6 3 1920, to 6 4 1920, that I last saw her alive on 6 3 1920, and that death occurred, on the date stated above, at 3:45 a.m. The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 7 ds. CONTRIBUTORY Bronchopneumonia (Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? observation

(Signed) J. B. Tellow M. D.

19 (Address) 2921 Odornell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Sacred Heart Cem June 5 1920

20 UNDERTAKER ADDRESS

Stephen J. Frankowski 1000 S. Linwood

D43750

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43750

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 E. Chaso

ST. 10 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur V. McShane

(a) RESIDENCE. No. 710 E. Chaso

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov., 17-1897

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) BookKeeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER Chas. J. McShane

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER Catherine Glenn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto. Md.

14

Informant (Address)

15

JUN 4 - 1920

ROBERT B. ERAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June, 3, 1920

17

I HEREBY CERTIFY, That I attended deceased from

October, 1919, to June 3, 1920.

that I last saw him alive on June 2, 1920.

and that death occurred, on the date stated above, at 7:00 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Coronary atherosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? u Date of

Was there an autopsy? u

What test confirmed diagnosis? Section

(Signed) Edward J. Coolahan, M. D.

6/3, 1920 (Address) 24 N. Fulton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cemetery.

DATE OF BURIAL

6/5 1920

20 UNDERTAKER

C. F. Evans & Son - 116 W. Mt. Royal Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43751

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 434 N. Fremont Ave. ST.: 18 WARD)2-FULL NAME Henrietta E. Downey(Residence in Baltimore: No. 434 N. Fremont Ave. St.: 18 yrs., mos. ds.)REGISTERED NO. C 138 D43751

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. I 4-COLOR OR RACE. Negro 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 17, 1902
(Month) (Day) (Year)

7-AGE, 18 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Domestic
(b) General nature of industry, business, or establishment in which employed (or employer). 070

9-BIRTHPLACE, (State or Country), Balti. City

10-NAME OF FATHER, James Downey

11-BIRTHPLACE OF FATHER (State or Country), Balti

12-MAIDEN NAME OF MOTHER Flourice Hardey

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas H. Johnson

(Address) 434 N. Fremont

15- MIN 4 - 1920 ROBERT E. ELAUTE

Filed May 21 1920 Baltimore City Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 2, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 14 1920, to June 2 1920, that I saw her alive on June 1 1920, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Puerperal Nephritis, acute

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James H. Doe M. D.

6-7, 1920 (Address) 739 George

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Harrisburg Pa DATE OF BURIAL, June 5, 1920

20-UNDERTAKER Sam N. Chase ADDRESS 1400 Mosher St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43752

CERTIFICATE OF DEATH.

D43752

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3208 Phil. Ad ST. 26 WARD)

2-FULL NAME

(a) RESIDENCE. No. 3208 Phil. Ad ST. 26 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14 1919

7 AGE Years 1 Months 1 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Elizabeth Berner (Address) 3208 Phil. Ad Ave.

15 Filed JUN 4 1920 ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1920

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1920, to June 3, 1920, that I last saw him alive on June 3, 1920, and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Stomach - pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex. etc. (Signed) Geo. F. Reuter, M. D.

, 19 (Address) 6 N. My

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Oak Lawn Cemetery June 15 1920

20 UNDERTAKER

George F. Reuter 1735 1/2 N. My

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Hk.

D43753

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43753

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes' Hospital*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mr. G. L. St. Leger

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

m.

4 COLOR OR RACE

W.

5 Single, Married, (Widowed,) or Divorced (write the word)

W.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Carpenter

6 DATE OF BIRTH (month, day, and year)

Oct 27 - 1830

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

89

7

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

Carpenter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind.

10 NAME OF FATHER

Quentin St. Leger

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind.

12 MAIDEN NAME OF MOTHER

?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

?

14

Informant (Address)

Miss S. St. Leger 1924 St. Gayette St.

15

Filed

Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 3 1920

17

I HEREBY CERTIFY, That I attended deceased from

7/21 1918 to 6/3 1920

that I last saw him alive on *6/3 1920*

and that death occurred, on the date stated above, at *6 P. m.*

The CAUSE OF DEATH* was as follows:

*Fracture of head of femur
arterio sclerosis, general*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Angina pectoris

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Physiological examination*

(Signed) *Samuel P. Alcega, M.D.*

, 19 (Address) *St. Agnes' Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Bethesda Cem

6/5/20

20 UNDERTAKER

Geo. J. Taylor, Fulton St. 1924 St. Gayette St.

JUN 4 - 1920

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43754

D43754

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3967 Roland Ave ST.: 13 WARD)

2-FULL NAME

Margaret Dunn Hayes

(a) RESIDENCE. NO.

3967 Roland Ave ST.: 13 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John P. Hayes6 DATE OF BIRTH (month, day, and year) March 17-18457 AGE Years 75 Months 2 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Michael Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Johanna Harrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

PARENTS

14 Informant (Address)

Miss. Agnes J. Hayes
3967 Roland Ave

15 Filed, 19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2-1920

17

I HEREBY CERTIFY, That I attended deceased from

May 27, 1920, to June 2, 1920,that I last saw her alive on June 2, 1920,and that death occurred, on the date stated above, at 9:15 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Abdomen
(Cancerous impregnation of Peritoneum)
Intestinal tumor (duration) 11 yrs. 11 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Agenda other than(Signed) Clinical A. Shelly M. D.3 1920 (Address) 3849 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral CemeteryJune 5 1920

20 UNDERTAKER

ADDRESS

Horace Burgee & Son3631 Falls Rd.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

JUN 4 - 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43755

D43755

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1432 Park Ave ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J. D. Williams(a) RESIDENCE. No. 1432 Park Ave. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18-18707 AGE Years Months Days If LESS than 1 day, hrs. or min. 50 — 15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) md.10 NAME OF FATHER Balrymple Williams11 BIRTHPLACE OF FATHER (city or town) Balro (State or country) md.12 MAIDEN NAME OF MOTHER Emma Jacobsen13 BIRTHPLACE OF MOTHER (city or town) Balro (State or country) md.14 Informant Maria Williams (Address) 1432 Park Ave.15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 31 192017 I HEREBY CERTIFY, That I attended deceased from May 18th, 1920, to June 30th, 1920, that I last saw her alive on June 2nd, 1920, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Combined sclerosis and pernicious anemia(duration) 5 yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) 6 yrs. 6 mos. 5 ds.18 Where was disease contracted ✓ If not at place of death?Did an operation precede death? No Date of ✓Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. M. Evans, M. D.Date of 1920 (Address) 1515 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Greenmount Cem

DATE OF BURIAL

6-5 1920

20 UNDERTAKER

Henry W. Jenkins & Sons Co

ADDRESS

Mculloh Orchard

THIS IS A PERMANENT RECORD. IT IS THE PROPERTY OF THE HEALTH DEPARTMENT, CITY OF BALTIMORE. IT IS TO BE KEPT IN THE HEALTH DEPARTMENT, CITY OF BALTIMORE, AND NOT TO BE LOANED, COPIED, OR IN ANY MANNER REPRODUCED WITHOUT THE WRITTEN PERMISSION OF THE HEALTH DEPARTMENT, CITY OF BALTIMORE. IT IS TO BE KEPT IN THE HEALTH DEPARTMENT, CITY OF BALTIMORE, AND NOT TO BE LOANED, COPIED, OR IN ANY MANNER REPRODUCED WITHOUT THE WRITTEN PERMISSION OF THE HEALTH DEPARTMENT, CITY OF BALTIMORE.

JUN 4 - 1920

D43756

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43756

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3318 Anchenoroly Terrace ST.: 13th WARD)

FULL NAME Oscar Henry Clark

(a) RESIDENCE. No. 3318 Anchenoroly Terrace ST.: 13th WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Elizabeth Clark

6 DATE OF BIRTH (month, day, and year) 1862 August 21

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
57 years 9 mos 14 days

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Treasurer of Baugh & Sons Company

(b) General nature of industry, business, or establishment in which employed (or employer) Fertilizers

(c) Name of employer Baugh & Sons Company

9 BIRTHPLACE (city or town) Baltimore City
(State or country) Maryland

10 NAME OF FATHER John F. Clark

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Sophia Seng

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)14 Informant G. E. Verelstiebert
(Address) 3318 Anchenoroly Terrace

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk,

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1920

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1920, to June 3, 1920, that I last saw him alive on June 3, 1920, and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

CONTRIBUTORY (Secondary)

(duration) 5 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phlegm at Segno

(Signed) Michael Gorb, M. D.

19 (Address) 2731 Rockwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

28 P43757

REGISTERED NO.
(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 4 WARD 1)

(a) RESIDENCE. NO. 1217 Glyndon Ave.

(Usual place of abode)
Length of residence in city or town where death occurred

Unknown

ST. WARD.
(If nonresident give city or town and State)
ds. How long in U. S., if of foreign birth? *Ind* yrs mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2nd, 1920

17 I HEREBY CERTIFY, That I attended deceased from
May 1st, 1920, to June 2nd, 1920,
that I last saw him alive on June 2nd, 1920,
and that death occurred, on the date stated above, at 1.45 p. m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

... (duration) ... yrs. ⁴ mos. ds

CONTRIBUTORY
(Secondary)
..... (duration) yrs. mos. ds

18 Where was disease contracted
if not at place of death? Unknown

Did an operation precede death? No Date of _____

Was there an autopsy? *no.*

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) George K. Williams M. D.

6-2-20 Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 UNDERTAKER	ADDRESS
Mrs. & Mrs. Jno. W. Trefel & Son	801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43758

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

D43758

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Anna Lutz

(a) RESIDENCE. No. 2038 Eutaw Place ST. WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, 2 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER John Francis Lutz

11 BIRTHPLACE OF FATHER (city or town) Annapolis (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Carlyle

13 BIRTHPLACE OF MOTHER (city or town) Millville (State or country) N. J.

14 Informant Hospital Records (Address) University Hospital

15 Filed 1920 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1920

17 I HEREBY CERTIFY, That I attended deceased from June 3, 19 20, to June 4, 19 20 that I last saw her alive on June 4, 19 20, and that death occurred, on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. 2 1/2 hrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) J. A. Buchness, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Annapolis Md

June 5 1920

20 UNDERTAKER

Harry H. Witzke

ADDRESS 1531 W. Lomb

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43759

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43759

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital 11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary E. Jean

(a) RESIDENCE. NO.

217 St. Helena Ave. St. Helena, Ind. Buffalo N. Y.

(Usual place of abode)

(If nonresident give city of town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1871

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

48

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

H. W. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Buffalo N. Y.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Hospital Records

Robert P. Harrison

15

Filed 1924, 19

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 3, 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 11, 1920, to June 3, 1920,

that I last saw her alive on *June 3, 1920*

and that death occurred, on the date stated above, at *12 noon*

The CAUSE OF DEATH* was as follows:

Papylomatous Cyst of Ovary with Cirrhosis of Liver

(duration) yrs. *12* mos. ds.

CONTRIBUTORY (Secondary)

General Peritonitis

(duration) yrs. mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *May 26, 1920*

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Operation and histology*

(Signed) *J. Clifton Deskeyne, M. D.*

June 3, 1920 (Address) *Maryland General Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Buffalo N. Y.

June 4, 1920

20 UNDERTAKER

ADDRESS

Harry H. Witzke

1531 W. Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43760

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43760

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 Greenmount Ave. ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 815 Greenmount Ave. ST. 10 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 11 1920

7 AGE — Years — Months — Days 23 If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Ind. (State or country)

10 NAME OF FATHER Ernest Clulde

11 BIRTHPLACE OF FATHER (city or town) Balto Ind. (State or country)

12 MAIDEN NAME OF MOTHER Grace B. Harrison

13 BIRTHPLACE OF MOTHER (city or town) Balto Ind. (State or country)

14 Informant (Address) Robert P. Harrison

JUN 4 - 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1920

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1920, to June 3, 1920, that I last saw him alive on June 3, 1920, and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation of Heart (duration) — yrs. — mos. 23 ds.

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John P. Wick, M. D.

6/4, 1920 (Address) 936 Greenmount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Londow Park June 5 1920

20 UNDERTAKER ADDRESS

Geo W Little 531 N. Fremont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact notation of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Hks.

D43761

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43761

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1703 Marshall ST. 23 WARD)

2-FULL NAME

(a) RESIDENCE. No. 1703 Marshall ST. 23 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. —mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Catherine Schaffer (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1873

7 AGE Years 47 Months 7 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Tim Hocking
(c) Name of employer Wm. Evans & Company

9 BIRTHPLACE (city or town) Balto (State or country) MD

10 NAME OF FATHER Wm. Schaffer

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) MD

12 MAIDEN NAME OF MOTHER Annie Pruby

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) MD

14 Informant Mrs. C. Schaffer (Address) 1703 Marshall St.

15 Filed Robert P. Harrison, Registrar

Funeral Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to June 2, 1920, that I last saw him alive on June 2, 1920, and that death occurred, on the date stated above, at 6 P. m. The CAUSE OF DEATH* was as follows:

Coronary of Stomach

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. 3 mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically
(Signed) R. P. Campbell M.D.
3, 1920 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER Mr. J. J. Brown ADDRESS 1311 High St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D43762

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43762

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *805 Ridgely* ST.: *21* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *7703 Horner Ave.*

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *23* yrs. mos. ds. How long in U. S., if of foreign birth? *life* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *7* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*

5a If married, widowed, or divorced

(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *— — 1872*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *70 — —*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Virginia*

10 NAME OF FATHER *Louis Powell*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Virginia*

12 MAIDEN NAME OF MOTHER *Mary Harchant*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Pa.*

14 Informant *Anna E. Bond* (Address) *1703 Horner Ave.*

15 Filed *Robert P. Harrison,* Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 3 1920*

17 I HEREBY CERTIFY, That I attended deceased from *May 3*, 19*20*, to *June 3*, 19*20*, that I last saw him alive on *June 2*, 19*20*, and that death occurred, on the date stated above, at *11 A* m. The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Harry Bright*, M. D.

(Address) *612 Columbia*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baths Ave *6/5 1920*

20 UNDERTAKER

ADDRESS

J. J. Fahey & Sons 1318 Light St

JUN 4 - 1920

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43763

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43763

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 N. E. Howard are 6 ST. 6 WARD)

2-FULL NAME

Frank J. Lugenmiller

(a) RESIDENCE. No.

105 N. E. Howard are 6 ST. 6 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Ottillie Lugenmiller

6 DATE OF BIRTH (month, day, and year) Dec 3 - 1856

7 AGE Years 63 Months 6 Days 075 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Penn.

10 NAME OF FATHER

Henry Lugenmiller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Barbara Rheinhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

PARENTS

14 Informant (Address)

Ottillie Lugenmiller
105 N. E. Howard are 6

Robert F. Harrison,

Registrar

Burial Permit Clerk.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 20 1920, to June 2 1920, that I last saw him alive on June 1 1920

and that death occurred, on the date stated above, at 87 m.

The CAUSE OF DEATH* was as follows:

Adeno-Carcinoma of Rectum

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 27, 1920

Was there an autopsy? No

What test confirmed diagnosis? T. Oursu

(Signed) John T. Oursu, M. D. (Address) Farmington Ave & Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Hof Redeema Benev 6/5/1920

20 UNDERTAKER ADDRESS 300 E Balto St

J. J. Moran

JUN 4 - 1920

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-12 H. P. Co. 1000 Bks.

D43767

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43767

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 431 N. Lakewood Ave ST. 6 WARD)

2-FULL NAME

Friedrich Beck

(a) RESIDENCE. No. 431 N. Lakewood Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Beck

6 DATE OF BIRTH (month, day, and year) Jan. 18-1882

7 AGE Years 38 Months 4 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Dennedy Iron Works

(c) Name of employer Balto Ind.

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Frank Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Ind.

12 MAIDEN NAME OF MOTHER Anna Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lillian Ouzborne (Address) 431 N. Lakewood Ave

Robert P. Harrison,

Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1920

17 I HEREBY CERTIFY, That I attended deceased from May 9 1920 to June 2 1920, that I last saw him alive on June 2 1920, and that death occurred, on the date stated above, at 10.30 a. m. The CAUSE OF DEATH* was as follows:

Mitral regurgitation

CONTRIBUTORY (duration) yrs. mos. ds. Acute dilatation heart -

Secondary (duration) yrs. mos. ds. 6 L

18 Where was disease contracted? If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? (Signed) C. J. Schmitt M. D.

19 (Address) 701 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Schmitt Cemetery 6/5/1920

20 UNDERTAKER J. G. Moran ADDRESS 3000 E. Balt. St.

JUN 4 1920

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 6-9-19-H. P. Co. 1000 Bks.

D43765

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43765

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 N. Brehm

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sarah Barton Stubbs

(a) RESIDENCE. NO.

417 N. Brehm

ST.

WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 41 yrs.

mos.

ds.

How long in U. S., if of foreign birth? Life yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Henry S. Stubbs

6 DATE OF BIRTH (month, day, and year)

Unknown 1879

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.

or min.

41

—

—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balti.

Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

"

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

Unknown

(State or country)

14

Informant

Address

Fenna Williams
417 N. Brehm St.

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 2, 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 29, 1920 to June 2, 1920,

that I last saw him alive on June 2, 1920,

and that death occurred, on the date stated above, at 3-10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

6.3, 1920 (Address) 120 1/2 Disgust St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel cemetery

June 5, 1920

20 UNDERTAKER

ADDRESS 1725

Mrs Robert A. Elliott Orlando

JUN 5 - 1920

Burial Permit Clerk

Information should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43766

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43766

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellwood Pauls

(a) RESIDENCE. No. 812 E. Pratt St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

Colored

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Robert Pauls

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Grace Betts

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Delaware

14

Informant (Address)

Hospital Records

H.T.H.

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st 1920

17

I HEREBY CERTIFY, That I attended deceased from April 30th 1920, to June 1st 1920,

that I last saw him alive on June 1st 1920,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY Tuberculous peritonitis (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed) George K. Williamson, M. D.

June 2, 1920 Address Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mount Auburn Cemetery

19

20 UNDERTAKER

JAMES H. DENNIS

ADDRESS

1303 PRESTMAN ST.

JUN 5 - 1920

Official Record Clerk

D43767

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43767

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3405 Esther Place* ST. *36* WARD)

2-FULL NAME

Ida Bruggman.

(a) RESIDENCE. No.

3405 Esther Place

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Jacob Bruggman.*

6 DATE OF BIRTH (month, day, and year)

Mich 4 - 1869

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*51**2**28*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Housework*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore
Md.*

10 NAME OF FATHER

Joseph King.

11 BIRTHPLACE OF FATHER (city or town)

Balto.

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Anna Brown

13 BIRTHPLACE OF MOTHER (city or town)

Balto.

(State or country)

Md.

14

Informant
(Address)*Jacob Bruggman.
3405 Esther Place.*

15

Filed

JUN 5 - 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 2 1920

17

I HEREBY CERTIFY, That I attended deceased from

*Jan. 16, 1920, to June 2, 1920.*that I last saw him alive on *June 1, 1920.*and that death occurred, on the date stated above, at *6.24 a.m.*

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma(duration) *2* yrs. mos. ds.CONTRIBUTORY
(Secondary)*Uterine Carcinoma*(duration) *2* yrs. mos. ds.18 Where was disease contracted
if not at place of death?*2232 Eastern*Did an operation precede death? *no* Date of *✓*Was there an autopsy? *no*What test confirmed diagnosis? *Physical*(Signed) *Geo. Heller*

M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

67-19 M Address 1937 Gough St

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cath Lawn Cem.

DATE OF BURIAL

June 5 1920

20 UNDERTAKER

Lilly & Ziehl

ADDRESS

403 S. W. 4th St

Information should be stated EXACTLY. PH. SICKNESS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43768

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43768

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 2 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUN 5 - 1920

Robert P. Harrison

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Pulmonary Thrombosis

Several

CONTRIBUTORY

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Duration) yrs. mos. ds.

(Signed) M. D.

4 June 1920 (Address)

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

John H. Ladin

June 4 1920

145

JUN 5 - 1920

Serial Permit Clerk.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Physicians should state state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43769

D43769

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1734 E. Oliver ST.; 8 WARD)

2-FULL NAME

(a) RESIDENCE. No. 1734 E. Oliver ST.; 3 2 mos. 24 ds.

(Usual place of abode)

Length of residence in city or town where death occurred

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth?

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6. 4. 20.

7 AGE 3 1/2 Years 3 Months 2 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER Chas. H. Nehus

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Lula R. Duer

13 BIRTHPLACE OF MOTHER (city or town) Martinsburg W. Va. (State or country)

14 Informant (Address) 1734 E. Oliver St. Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6. 4. 19 20.

I HEREBY CERTIFY, that I attended deceased from June 2nd to June 4th 19 20.

that I last saw him alive on June 4th 19 20.

and that death occurred, on the date stated above, at 11 20 A. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos. ds. CONTRIBUTORY (Secondary) Violent Infection (duration) yrs. mos. ds.

18 Where was disease contracted? At home If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Culture (Signed) H. A. Meyer, M. D.

(Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

JUNE 5 - 1920

Daniel Permit Clerk

D43770

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43770

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1339 Sigwith ST.; 9 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1339 Sigwith St.; 60 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

M

4-COLOR OR RACE

W5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

May 31, 1920
(Month) (Day) (Year)

7-AGE,

75 yrs., mos., ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Merial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 4, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 3 1920, to June 4 1920, that I saw him alive on June 4 1920, and that death occurred, on the date stated above, at 12:40 m. The CAUSE OF DEATH* was as follows:Lobar pneumonia
(Duration).....yrs.....mos..3..ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

Herbert C. Knapp, M. D.
June 4, 1920 (Address) 1216 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Emmanuel Cemetery June 7, 1920

20-UNDERTAKER

ADDRESS

Robert J. Jones 14424 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION and state important. See instructions on back of certificate.

JUN 5 - 1920

Information should be carefully supplied. AGE should be stated EXACTLY. PH. SICKNESS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43771

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43771

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 Leadenhall ST.: 23 WARD)

2-FULL NAME

Ethel Steward

(a) RESIDENCE. No. 814 Leadenhall ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE col 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Aug 16 1918

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 1 9 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md (State or country)

10 NAME OF FATHER Ethel Steward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Alice Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Alice Steward (Address) 814 Leadenhall St

15 Robert P. Harrison, Registrar

JUN 5 - 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd 1920

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1920, to June 3, 1920, that I last saw her alive on June 3, 1920, and that death occurred, on the date stated above, at 10 P. m. The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY Convulsions (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. H. Harrison M. D.

, 19 (Address) 140 W. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Auburn Ct June 5 1920

20 UNDERTAKER ADDRESS

L. E. Thompson 101 W. Mount

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43772

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *603 China* ST.; *22* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *603 China* St.; *30* yrs., *0* mos., *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *Feb*, *1865*
(Month) (Day) (Year)7-AGE, *55* yrs., *0* mos., *0* ds. If LESS than 1 day, hrs. or min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer) *040*9-BIRTHPLACE, (State or Country), *MD*10-NAME OF FATHER, *unknown*11-BIRTHPLACE OF FATHER (State or Country), *unknown*12-MAIDEN NAME OF MOTHER, *unknown*13-BIRTHPLACE OF MOTHER (State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Martha Kent*(Address) *603 China St*

15- Robert P. Harrison,

JUN 5 1920 191. Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 3*, *1920*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 2* 1920, to *June 3* 1920, that I saw him alive on *June 2* 1920, and that death occurred, on the date stated above, at *2:30* p. m.

The CAUSE OF DEATH* was as follows:

Myocardial infarction

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Myocardial infarction*

(Duration) yrs. mos. ds.

(Signed) *Dr. J. H. Harrison* M. D.*June 4*, 1920 (Address) *712 S. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mt Auburn Ct*DATE OF BURIAL, *June 5*, 192020-UNDERTAKER *St. L. Brown & Son*ADDRESS *Vol 100 Montg*

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1143773

HEALTH DEPARTMENT—CITY OF BALTIMORE

1143773

CERTIFICATE OF DEATH.

175-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* ST. *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Michael Danaku

(a) RESIDENCE. NO. *412 Park Ave*

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. *40 yrs.* mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 7, 1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

72

0

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Samuel Danaku

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Margaret Mc Coy

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Hosp. Record Mary Hospital

15

JUN 5, 1920 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 2, 1920*

17

I HEREBY CERTIFY, That I attended deceased from *April 26, 1920* to *June 2, 1920* that I last saw him alive on *June 2, 1920*

and that death occurred, on the date stated above, at *7:40 A.M.*

The CAUSE OF DEATH* was as follows:

Fracture neck Right Femur
6th Co.

(duration) yrs. mos. *36* dg.
CONTRIBUTORY *Hypostatic Pneumonia*
(Secondary) (duration) yrs. mos. *10* da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No* *W. T. Riley*

What test confirmed diagnosis? *Guinea*

(Signed) *Wm. O. Ridge* M. D.

6/2, 1920 (Address) *Mary Hospital, (over)*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Vincent's Cem. 6/3 1920

20 UNDERTAKER

ADDRESS

Chas. F. Evans & Son 118 W. Mt. Royal Ave

D43774

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43774

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Murq Noap*)

ST.:

WARD) *15*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edward H. Garbie(a) RESIDENCE. NO. *2927 Walbrook Ave.*

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. — mos. ds.How long in U. S., if of foreign birth *Life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 16, 1859*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*65**10**16*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer O & O

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

United R.R. Co.

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

John Garbie

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa

12 MAIDEN NAME OF MOTHER

Sarah S. Garbie

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa

14

Informant (Address)

Mrs. Ebra Garbie 2927 Walbrook Ave

JUN 5 - 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *6/3* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

*5/20*19 *20*to *6/3*19 *20*that I last saw him alive on *6/3*19 *20*and that death occurred, on the date stated above, at *4* a. m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy of Prostate(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic Interstitial Hyp.(duration) *6* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *4/1/20*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

Lewis S. Ridge

M. D.

43, 1920 (Address)

Murq Noap

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park Cem**June 5 1920*

20 UNDERTAKER

Joseph B. Cook

ADDRESS

1003 1st St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43775

CERTIFICATE OF DEATH.

X 120 D43775

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Woman's Hospital

ST.:

14

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Susie Ellen Carter

(Residence in Baltimore: No.

Catonsville, Md.

St.; 51 yrs., 4 mos., 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, *married*, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH.

Jan. 15, 1869
(Month) (Day) (Year)

7-AGE,

51 yrs., 4 mos., 20 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

037

9-BIRTHPLACE,
(State or Country),

Virginia

10-NAME OF FATHER,

Benton Carter

11-BIRTHPLACE OF FATHER
(State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Catherine Mahoney

13-BIRTHPLACE OF MOTHER
(State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Frank A. Worthington

(Address)

Woman's Hospital

15-

Robert P. Harrison,

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 5, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 23, 1920, to June 5, 1920, that I saw her alive on June 5, 1920, and that death occurred, on the date stated above, at 7:18 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia - Uterine

Operation -

Pyelitis - Uremia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

Chronic Nephritis

(Duration) ... yrs. ... mos. ... ds.

(Signed)

Frank A. Worthington, M. D.

June 5, 1920 (Address) Woman's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the 31 State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Catonsville, Md.

19-PLACE OF BURIAL OR REMOVAL

London Park Co.

DATE OF BURIAL

June 8, 1920

20-UNDERTAKER

Joseph P. Cook

ADDRESS

1003 N. E. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 5 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43776

CERTIFICATE OF DEATH.

D43776

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 165 Monte bello Terrace ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE

No. 165 Monte bello Terrace ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 4mos. 8

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan. 27 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore
Maryland

10 NAME OF FATHER

Mr E. Neilson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore
Maryland

12 MAIDEN NAME OF MOTHER

Maud Schaeffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore
Maryland

14

Informant (Address)

Mr E. Neilson
165 Monte bello Terrace

JUN 5 - 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 4 1920

17

HEREBY CERTIFY, That I attended deceased from

Jan 27 1920 to June 4 1920that I last saw her alive on June 4 1920and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration)

yrs.

mos. 8

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos. 8

ds.

18 Where was disease contracted if not at place of death?

Same

Did an operation precede death?

No

Date of

none

Was there an autopsy?

No

What test confirmed diagnosis?

Specs of tissue from
Femur & pelvis

(Signed)

Vernon J. Keely

M. D.

Address

3701 - Fair Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park CemJune 5 1920

20 UNDERTAKER

ADDRESS

Joseph B. Cook1003 N. Baltimore

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43777

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43777

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leroy Gilmore

(a) RESIDENCE (NO. 26 McCulloh St.) ST. 1026 WARD. McCulloh

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Unknown

mos.

ds. How long in U. S. If of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE Years 30 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Steward 074

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town) (State or country)

North Carolina

10 NAME OF FATHER John Gilmore

11 BIRTHPLACE OF FATHER (city or town) (State or country)

North Carolina

12 MAIDEN NAME OF MOTHER

Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

North Carolina

14 Informant Hospital Records (Address) M.T.H.

15 Filed Robert P. Harrison, Registrar

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd, 1920

17

I HEREBY CERTIFY, That I attended deceased from June 1st, 19 20, to June 3rd, 19 20.

that I last saw him alive on June 3rd, 19 20.

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 6 (?) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? T.B. in sputum

(Signed) George W. Harrison, M. D.

6-5-20, 19 20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Inwood R. Co. June 5 19 20

20 UNDERTAKER

Edward Ringgold 1463 McCulloh St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43778

CERTIFICATE OF DEATH.

63-061 D43778

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1401 Mosher* ST. *16* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE, No. *1401 Mosher* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *10-19-1880*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 5th 1920*I HEREBY CERTIFY, that I attended deceased from *May 24th 1920* to *June 4th 1920*.that I last saw her alive on *June 4th 1920* and that death occurred, on the date stated above, at *8:30 a.m.*

The CAUSE OF DEATH* was as follows:

Acute Poliomyelitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 1920 (Address) *2215 N. North Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43779

CERTIFICATE OF DEATH.

D43779

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3532* Frederick Rd. ST.: *10* WARD)

2-FULL NAME

John Henry Schnepfe

(a) RESIDENCE. NO. *3532* Frederick Rd. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 14 - 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Norman J. Schnepfe

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Elsa C. Merkel

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Norman J. Schnepfe 3532 Frederick Rd.

15

Filed JUN 6 12 1920

ROBERT E. KAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 5 1920

17

HEREBY CERTIFY, That I attended deceased from

May 21 1920 to June 5 1920

that I last saw him live on *June 5 1920*

and that death occurred, on the date stated above, at *6 P.M.*

The CAUSE OF DEATH* was as follows:

Erysipelas - moving chest back & arms

(duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

Gangrene of spine

(duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

C. pneumoniae

(Signed) *J. M. C. Hols* M. D.

, 19 (Address) *904 N. Charles St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Soudon Park Cemetery

June 6 1920

20 UNDERTAKER

J. W. Offutt, Jr.

ADDRESS

221 Bayard St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43780

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-089 D43780

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3085 Vincent ST.: 19 WARD)

2-FULL NAME

Mildred Wyatt

(Residence in Baltimore: No. 3088 Vincent

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Caucasian

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

Single

6-DATE OF BIRTH,

Feb. 4, 1920
(Month) (Day) (Year)

7-AGE,

4 yrs. 4 mos. ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

None

9-BIRTHPLACE.

(State or Country),

Balt City

10-NAME OF FATHER,

Noah Wyatt

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Lillian Wyatt

13-BIRTHPLACE OF MOTHER

(State or Country),

Balt City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cecilia Jones

(Address) 3088 Vincent

15-

JUN 6 - 1920

ROBERT B. KRAUTER

Filed

191

Baltimore Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 4, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, au-

Inquest find that said deceased came to his death (Inquest, au-
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute Bronchitis

(Duration) yrs. mos. ds.

(Signed) James M. Tenth M. D.

(Coroner.)

June 5, 1920 (Address) 700 E. Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn

DATE OF BURIAL,

June 6th, 1920

20-UNDERTAKER

A. Jones

ADDRESS

207 S. Stricker

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square* ST.: *16* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *William H. Rice*(a) RESIDENCE. NO. *706 N. B. Mill* ST.: *15* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. *1* mos. *1* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Widowed*6 DATE OF BIRTH (month, day, and year) *Unknown*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *about 40*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*(b) General nature of industry, business, or establishment in which employed (or employer) *04*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Md.*10 NAME OF FATHER *William H. Rice*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Walter Pears*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *Md.*14 Informant *William H. Rice* (Address) *706 N. B. Mill St. Aberdeen Harford Co. Md.*15 *JUN 6 - 1920* *ROBERT B. FLAHERTY* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 3* 19 *20*17 I HEREBY CERTIFY, That I attended deceased from *May 31*, 19 *20*, to *June 3rd*, 19 *20*, that I last saw him alive on *June 3rd*, 19 *20*, and that death occurred, on the date stated above, at *5 P. m.* The CAUSE OF DEATH* was as follows:*Operative Shock*CONTRIBUTORY (Secondary) *Intestinal Obstruction* (duration) yrs. mos. ds. (duration) yrs. mos. *5* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *June 3-20*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Bernard French* M. D.1/4, 1920 (Address) *1707 E. Broadway Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER *JAMES H. DENNIS* ADDRESS

1303 PRESTMAN ST.

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUR- CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43782

D43782

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 Augusta Ave ST.: 200 WARD)

2-FULL NAME

Eliza Thomas

(a) RESIDENCE. NO.

(Usual place of abode)

24 Augusta Ave ST.,

WARD. 20

Length of residence in city or town where death occurred

10 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Sept 3 1888

6 DATE OF BIRTH (month, day, and year)

Sept 3 1854

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

65

9

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sale Lady

(b) General nature of industry, business, or establishment in which employed (or employer)

Dept Store

(c) Name of employer

Stewart's

9 BIRTHPLACE (city or town) (State or country)

New York City

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Irish

12 MAIDEN NAME OF MOTHER

Irish

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Irish

14

Informant (Address)

Bertha Ham South Baltimore Hospital

15

Filed

JUN 6 - 1920

ROBERT B. TRAUBEL

Registrar

Barial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1920

17

I HEREBY CERTIFY, That I attended deceased from June 2 1920, to June 4 1920, that I last saw her alive on June 4 1920.

and that death occurred, on the date stated above, at 1.15 p.m.

The CAUSE OF DEATH* was as follows:

Erysipelas of face following boil

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

Toxaemia

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

boiled June 1

Did an operation precede death?

Date of by Dr. Traubel

Was there an autopsy?

no

What test confirmed diagnosis?

none

(Signed)

Henry H. Hahn

M. D.

6/5/1920 (Address)

23 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenwood N.Y. June 7 1920

20 UNDERTAKER

ADDRESS

Joseph Syfer 1600 N. Market

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43783

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1509 Fairmount Ave.* WARD *6*)

2-FULL NAME

(Residence in Baltimore: No. *1509 Fairmount Ave.* St.; *20* yrs., *2* mos., *1* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*Col.*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

Unknown, 1873
(Month) (Day) (Year)

7-AGE

47 yrs., *2* mos., *2* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work
(b) General nature of industry, business, or establishment in which
employed (or employer)*Housework*
*Domestic*9-BIRTHPLACE
(State or Country)*Baltimore City, Md.*

10-NAME OF FATHER

*Thomas Mack*11-BIRTHPLACE OF FATHER
(State or Country)*Baltimore City, Md.*

12-MAIDEN NAME OF MOTHER

*Mary Wheeler*13-BIRTHPLACE OF MOTHER
(State or Country)*Baltimore City, Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

George Hand

(Address)

1509 Fairmount Ave.

15-

Filed

JUN 6 - 1920

191

ROBERT A. ERAUTER

Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 1, 1920, *3* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
June 1, 1920, to *June 3*, 1920,
that I saw her alive on *June 1*, 1920,and that death occurred, on the date stated above, at *9:30 p.m.*

The CAUSE OF DEATH was as follows:

*Lobar Pneumonia**about two weeks*(Duration) *about 6* yrs., *7* mos., *1* ds.CONTRIBUTORY
(Secondary)*Sudden heart failure*
about two weeks(Signed) *William Field* M. D.
4 June, 1920 (Address) *475 N. Caroline St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *20* yrs., *2* mos., *1* ds. In the State *20* yrs., *2* mos., *1* ds.Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL

Asbury Cemetery

DATE OF BURIAL

June 6, 1920

20-UNDERTAKER

Mr. Robert A. Erauter

ADDRESS

1725

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43784

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D43784

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 E. Preston

ST.: 10

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Levere Stoner

(a) RESIDENCE. No. 707 E. Preston

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 2/1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

69

9

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Railroad Conductor

(b) General nature of industry, business, or establishment in which employed (or employer)

073

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pa.

10 NAME OF FATHER

Christie Stoner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Mary Spang

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa.

14

Informant (Address)

Jennie Stoner
707 E. Preston

15

Filed

JUN 6 - 1920

(Union Station)

ROBERT H. ELAETER
RegistrarBurial Permit Clerk
(Jennie M. Stoner)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 5th 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 20, 1920, to June 5th, 1920,that I last saw him alive on June 4th, 1920,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Acute Prostatitis

(duration)

yrs.

mos.

16 ds.

CONTRIBUTORY (Secondary)

Chronic Nephritis

(duration)

3 yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

clinical

(Signed)

Wm. B. Carver, M. D.

6-5, 1920 (Address)

707 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

millsburg Pa.

June 7/20 19

20 UNDERTAKER

Wm. Cook

ADDRESS

707 E. Math

D43785

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154 D43785
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1930 W. Lafayette Ave. ST. 16 WARD)

2-FULL NAME Martha E. Thomas

(a) RESIDENCE. No. 1930 W. Lafayette Ave. ST. 16 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Joseph B. Thomas

6 DATE OF BIRTH (month, day, and year) Apr 2 1884

7 AGE Years 35 Months 9 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) London Co. (State or country) Virginia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Luther Thomas (Address) 1930 W. Lafayette Ave.

15 JUN 6 - 1920 REGISTRAR Robert H. Smith

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1920

17 I HEREBY CERTIFY, that I attended deceased from June 4, 1920 to June 4, 1920 that I last saw her alive on June 4, 1920

and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Old age

CONTRIBUTORY

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Davis, M. D.

. 19 (Address) 2108 Broadfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 ADDRESS

21 ADDRESS

22 ADDRESS

23 ADDRESS

24 ADDRESS

25 ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DEATH is very important. See instructions on back of certificates.

Information should be carefully supplied. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43786

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43786

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

New City Hospital

ST.:

WARD)

2-FULL NAME

Lawrence Welsh

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1865

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

55

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Gen. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

*Hospital Records
New City Hospital*

15

File

JUN 6 - 1920

ROBERT F. FLAHERTY
Registrar

Barial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6-3

19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

8-24, 19 *18*, to *6-3*, 19 *20*

that I last saw him alive on *6-3*, 19 *20*

and that death occurred, on the date stated above, at *10⁴⁵/P.* m.

The CAUSE OF DEATH* was as follows:

*Acute + Chronic Vegetative
Endocarditis*

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Hemiplegia; Embolism

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *Yes*

What test confirmed diagnosis? *no special test*

(Signed) *J. F. Pessier*, M. D.

6-3, 1920 (Address) *Gray View House*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Sacred Heart Cem.

DATE OF BURIAL

June 7 1920

20 UNDERTAKER

Lilly and Zeller

ADDRESS

403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *12* WARD)

2-FULL NAME

Margaret Kuhnback

(a) RESIDENCE. NO.

(Usual place of abode)

401 S 4th St. City ST. *12* WARD.

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

2

6 DATE OF BIRTH (month, day, and year)

Oct 16 - 1856

7 AGE

Years *63*

Months *8*

Days *12*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

OOD

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany -

10 NAME OF FATHER

Sebastian Geldenhook

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Julianne Hillenreiter

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

John H. Records

15

JUN 6 - 1920

ROBERT A. FAUTER
Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 4* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

June 3 19 *20*, to *June 4* 19 *20*,

that I last saw her alive on *June 4* 19 *20*,

and that death occurred, on the date stated above, at *2 55 P. m.*

The CAUSE OF DEATH* was as follows:

Acute Pericarditis, bilateral

(duration) *0* yrs. *one* mos. — ds.

CONTRIBUTORY (Secondary)

Prolapsus uteri et Vesicae

(duration) *30* yrs. — mos. — ds.

18 Where was disease contracted

if not at place of death? *at home*

Did an operation precede death? *no* Date of *0*.

Was there an autopsy? *yes*.

What test confirmed diagnosis? *autopsy*.

(Signed) *Lawrence R. Wharton* M. D.

(Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Sacred Heart Cem.

DATE OF BURIAL

June 8 19 *20*

20 UNDERTAKER

Lilly and Ziehl

ADDRESS

403 S. Mt. St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43788

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D43788

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *North Meigs 72*) WARD
2-FULL NAME *George W. Revell*
(Residence in Baltimore: No. *2840 St Paul st*)

REGISTERED NO. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
St. (yrs., *3*) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *M.* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)
6-DATE OF BIRTH, *Jan 26, 1886*
(Month) (Day) (Year)
7-AGE, *34 yrs., 4 mos., 12 ds.* If LESS than 1 day, hrs. or min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Merchant* (b) General nature of industry, business, or establishment in which employed (or employer) *Merchant*

9-BIRTHPLACE (State or Country), *Accomack Co Va*
10-NAME OF FATHER, *W. Revell*
11-BIRTHPLACE OF FATHER (State or Country), *Accomack Co Va*
12-MAIDEN NAME OF MOTHER, *Eager H. Coleman*
13-BIRTHPLACE OF MOTHER (State or Country), *Accomack Co Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *I Revell*
(Address) *2840 St Paul st*

15- *JUN 6 - 1920* 101. *ROBERT A. KRAUTER*
Filed. *Burial Place Regular*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 3, 1920*
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy, or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Calculus of disease of heart
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) *Arteriosclerosis*
(Signed) *John H. Harrison* M. D. (Coroner)
Address *732 Roland*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Quind Ridge* DATE OF BURIAL, *June 7, 1920*
20-UNDERTAKER, *Geo. H. M. Coe* ADDRESS *2503 E. ...*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43789

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 N. Calhoun

ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Robert Tudor

(Residence in Baltimore: No. 504 N. Calhoun

St.; 86 yrs., 5 mos., 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widower
(Write the word.)

6-DATE OF BIRTH, December 9, 1833
(Month) (Day) (Year)

7-AGE, 86 yrs., 5 mos., 16 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Cashier
(b) General nature of industry, business, or establishment in which employed (or employer), Safe Deposit & Trust Co.

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, John Tudor
11-BIRTHPLACE OF FATHER (State or Country), Baltimore
12-MAIDEN NAME OF MOTHER, Sarah Ogden
13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence M. Tudor

(Address) 601 N. Carrollton

15-

JUN 6 - 1920

ROBERT B. LEAUTER

Baltimore, Md.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 4, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1912, to June 4, 1920, that I saw him alive on June 3, 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Apoplexy
(Duration) yrs. mos. ds.

CONTRIBUTORY.... Act age
(Secondary) (Duration) yrs. mos. ds.

(Signed) Geo. T. Kemp M. D.
June 5, 1920. (Address) St. James Apartment

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, June 7, 1920

20-UNDERTAKER, George J. Smith

ADDRESS 1000 N. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1043790

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48790

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1900 7 Baym ST.; 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 1900 4 Baym ST., 15 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Rose Morrison

6 DATE OF BIRTH (month, day, and year)

June 8/66

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

53

11

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

Brooklands

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Hampden, Md.

10 NAME OF FATHER

Wm. A. Morrison

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Perryman, Md.

12 MAIDEN NAME OF MOTHER

Ann E. Taylor

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant

(Address)

Rose E. Morrison

1900 W. Baym St.

ROBERT A. TROTTER

15

Filed

JUN 6 - 1920

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 4 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to June 4, 1920,

that I last saw him alive on June 3, 1920,

and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis,

Fracture of femur (duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood test

(Signed) O. C. Stoughton, M. D.

, 19 (Address) 1479 W. Baym St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

F. A. Krause & Son 703 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

043791

HEALTH DEPARTMENT—CITY OF BALTIMORE

043791

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 S. Ellwood ST.: WARD)

2-FULL NAME

John P. Gillespie

(a) RESIDENCE. NO. 916 S. Ellwood ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary G. Gillespie

6 DATE OF BIRTH (month, day, and year) Jan 17-1870

7 AGE Years 50 Months 4 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Old & own Bank

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md (State or country)

10 NAME OF FATHER J. H. Gillespie

11 BIRTHPLACE OF FATHER (city or town) Infant (State or country)

12 MAIDEN NAME OF MOTHER Bridget Gillespie

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant (Address) Mary G. Gillespie 916 S. Ellwood ST.

15 Filed JUN 6-1920 ROBERT E. LAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1920, to June 4, 1920, that I last saw him alive on June 4, 1920, and that death occurred, on the date stated above, at 8 17 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) nephritis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Urinary Test

(Signed) W. L. Burke M. D.

. 19 (Address) 3042 Hudson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Catholic Cemetery 6/7 1920

20 UNDERTAKER ADDRESS 3000 E. Baltimore

J. G. Moran

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43792

CERTIFICATE OF DEATH.

X 114 D43792

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mt. Hope Retnat*)ST.: *28* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary S. Rohobaugh

(a) RESIDENCE. NO.

Berkely Springs W. Va

ST.

WARD.

(Berkely Springs W. Va)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *0* yrs. *3* mos. *0* ds. How long in U. S., if of foreign birth? *43* yrs. *10* mos. *—* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, divorced, or separated

(or) WIFE of

*Jr. R. Rohobaugh*6 DATE OF BIRTH (month, day, and year) *Aug-?-1876*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*43**10**—*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home work - 837

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Bilington*(State or country) *W. Va*

10 NAME OF FATHER

Wm Hife

11 BIRTHPLACE OF FATHER (city or town)

Bilington

(State or country)

W. Va

12 MAIDEN NAME OF MOTHER

Anna Poling

13 BIRTHPLACE OF MOTHER (city or town)

Bilington

(State or country)

W. Va

14

Informant (Address)

*Records of Mt Hope Retnat
Mt Hope Baltimore Md.*

15

File *JUN 7 - 1920**ROBERT E. LAUTER**Burial Permit 0100*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 6 1920

17

I HEREBY CERTIFY, That I attended deceased from

*Mar-20 1920 to June 6th 1920*that I last saw her alive on *June 6th 1920*and that death occurred, on the date stated above, at *5:50 P. m.*

The CAUSE OF DEATH* was as follows:

Hepatitis - Post operation for Gall Stones -(duration) *0* yrs. *3* mos. *0* ds.

CONTRIBUTORY (Secondary)

Anemia Depressive(duration) *0* yrs. *3* mos. *0* ds.

18 Where was disease contracted if not at place of death?

Berkely Springs -

Did an operation precede death?

Yes Date of *Nov. '19*

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed) *Frank J. Flannery* M. D.June 6th 1920 (Address) *Frank J. Flannery*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Parsons St. Va.**June 7/ 1920*

20 UNDERTAKER

STEWART & MOWEN COMPANY

(WILLIAM F. WOODEN, Successor)

108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43793

CERTIFICATE OF DEATH.

39 D43793

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE,

(Informant)

(Address)

15-

Filed

191

ROBERT B. ELAUTE

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

June 4, 1920 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

STEWART & MOWEN COMPANY

WILLIAM F. WOODEN, Successor

108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

043794

CERTIFICATE OF DEATH.

X 63 D43794

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Mt Hope Retmar

ST.: 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Camilla Wilson

(a) RESIDENCE. NO.

Prov. Hospital Washington D.C.

WARD.

Washington D.C.

(Usual place of abode)

(If nonresident give city and State)

Length of residence in city or town where death occurred

0 yrs.

3 mos.

0 ds.

How long in U. S., if of foreign birth?

Life yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Don't Know

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

Don't know - think abt 97

0

0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pennsylvania

10 NAME OF FATHER

Sam. Shumrry (?)

11 BIRTHPLACE OF FATHER (city or town) (State or country)

France

12 MAIDEN NAME OF MOTHER

Marg. E. Wertz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Washington D.C.

14

Informant (Address)

Records of Mt Hope Retmar

15

Filed

19

JUN 7 - 1920

ROBERT E. KRAUTER Registrar
Burial Permit Closed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 6th

1920

17

I HEREBY CERTIFY, That I attended deceased from

March 1920

to

June 6th

1920

that I last saw her alive on

June 5th

1920

and that death occurred, on the date stated above, at

3:45 P. M.

The CAUSE OF DEATH* was as follows:

Paralysis - (Bulbar)

CONTRIBUTORY

(Secondary)

Arterio Sclerosis - Cerebral

Renal Disease

(duration) 0 yrs. 0 mos. 1/2 ds.

For years -

18 Where was disease contracted if not at place of death?

Washington D.C.

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

Frank J. Flannery

M. D.

June 6th 1920

(Address)

Mt Hope Retmar

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery - June 7/1920
STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43795

CERTIFICATE OF DEATH.

REGISTERED NO.

D43795

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dolly Eubank(a) RESIDENCE. No. 1430 Lawrence St.ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

(yrs. 6)

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	<u>Colored</u>	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofUnknown Rev Eubank6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
36	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)14 Informant Hospital Records(Address) New City Hospital.15 Filed JUN 7 - 1920 ROBERT A. ELSTER Registrar

Bureau of Health Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1920

17

I HEREBY CERTIFY, That I attended deceased from May 27, 1920, to June 3, 1920.that I last saw her alive on June 3, 1920.and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis(duration) 31 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Hemiplegia, Cerebral
Hemorrhage (duration) 6 yrs. mos. ds.18 Where was disease contracted
if not at place of death?CityDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

Wassermann(Signed) J. F. Pessel, M. D.19 PLACE OF BURIAL, CREMATION OR REMOVAL New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 UNDERTAKER Schwartz, Curtis ADDRESS 1725

20 UNDERTAKER

Mrs. Robt. A. ElliottCAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43796

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1032 Patapoco ST.; 23 WARD)

2-FULL NAME

(a) RESIDENCE. No. 1032 Patapoco ST., 23 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

REMARKS of (or) STATE

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

JUN 7 - 1920

ROBERT B. TRAUBER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 1, 1920, to June 4, 1920,

that I last saw him alive on June 3, 1920,

and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Acute Infectious

Ephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Trauma Coma

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? (Signed) W. H. Harrison, M. D.

(Address) 835 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross Cem. A. A. June 7 1920

20 UNDERTAKER

M. G. Flynn

1422 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D43797

REGISTERED NO. C

D43797

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1203 Valley

ST. 10 WARD)

2-FULL NAME Margaret Mary Wallace

(Residence in Baltimore: No. 1203 Valley

St.: yrs. mos. / ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH June 4, 1920 (Month) (Day) (Year)

7-AGE If LESS than 1 day, 20 hrs. yrs. mos. ds. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) 1203 Valley St

10-NAME OF FATHER John Wallace

11-BIRTHPLACE OF FATHER Md

12-MAIDEN NAME OF MOTHER Ellen M. Weir

13-BIRTHPLACE OF MOTHER Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Wallace (Address) 1203 Valley St

15.

JUN 7 - 1920

ROBERT B. KRAUTER

Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 5, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 4, 1920, to June 4, 1920, that I saw her alive on June 4, 1920, and that death occurred, on the date stated above, at 8:30 p. m. The CAUSE OF DEATH* was as follows:

Premature Birth, child living 20 hours. Improper down foramen oval (Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Joseph J. Keating M. D. June 6, 1920 (Address) 1812 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cathedral June 7, 1920

20-UNDERTAKER ADDRESS

H. C. Wiedefeld 914 Greenmount

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43798

CERTIFICATE OF DEATH.

REGISTERED NO. C

D43798

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Holbrook ST.; 9 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1622 Holbrook St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Male</u>	4-COLOR OR RACE, <u>white</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <u>Single</u>
-----------------------	----------------------------------	---

6-DATE OF BIRTH, <u>Feb. 15</u> , <u>1919</u> (Month) (Day) (Year)
--

7-AGE, <u>1</u> yrs., <u>3</u> mos., <u>20</u> ds.	IF LESS than 1 day, hrs. or min.?
---	--

8-OCCUPATION: (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer).....	<u>none</u>
--	-------------

9-BIRTHPLACE, (State or Country), <u>Baltimore City</u>
--

PARENTS.	10-NAME OF FATHER, <u>Thomas</u>
	11-BIRTHPLACE OF FATHER (State or Country), <u>Ireland</u>
	12-MAIDEN NAME OF MOTHER, <u>Nora Roland</u>
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Ireland</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Roland
(Address) 1604 E. Biddle15- JUN 7 - 1920 ROBERT E. EBAUTER
Filed..... 191.....Burial Permit 10000

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, <u>June</u> , <u>6</u> , <u>1920</u> (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 29 1920, to June 6 1920, that I saw him alive on June 6 1920, and that death occurred, on the date stated above, at 5:35 p. m.

The CAUSE OF DEATH* was as follows:
Pneumonia following
measles

(Duration)..... yrs..... mos. <u>12</u> ds.

CONTRIBUTORY (Secondary) <u>measles</u>

(Signed) <u>R. O. Cannon</u> M. D.

<u>June 6</u> , 19 <u>20</u> . (Address) <u>1241 N. Carroll St.</u>

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds.	In the State..... yrs..... mos..... ds.
--	---

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

<u>Cathedral</u>	DATE OF BURIAL, <u>June 7th 1920</u>
------------------	--------------------------------------

20-UNDERTAKER <u>Martin Maher & Sons</u>	ADDRESS <u>1827 W. 7th St.</u>
--	--------------------------------

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43799

CERTIFICATE OF DEATH.

REGISTERED NO.

D43799

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 N. Vincent ST.: 19 WARD)

2-FULL NAME

Sarah Jane Scott

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE, No.

213 N. Vincent ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced (write the word) Child5a If married, widowed, or divorced HUSBAND of (or) WIFE of X6 DATE OF BIRTH (month, day, and year) Oct 11 - 19097 AGE Years 10 Months 7 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Joe B. Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country)

MD

12 MAIDEN NAME OF MOTHER

Lillie Bury

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Lillie Scott
213 N. Vincent

15

JUN 7 - 1920ROBERT B. ELSTON

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 19 2017 I HEREBY CERTIFY, That I attended deceased from May 11, 19 20, to June 4, 19 20, that I last saw him alive on June 4, 19 20, and that death occurred, on the date stated above, at 11:55 a.m. The CAUSE OF DEATH* was as follows:Acute Endocarditis
(duration) yrs. mos. 14 ds.
CONTRIBUTORY Rheumatism
(Secondary) (duration) yrs. mos. 27 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no, Date ofWas there an autopsy? noWhat test confirmed diagnosis? Regular

(Signed)

G. L. Link

M. D.

Address 1313 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

mt Auburn CemJune 9 19 20

20 UNDERTAKER

ADDRESS

Joseph A. Farrell2319 Division

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43800

CERTIFICATE OF DEATH.

28 D43800
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3614 Rail Road Av ST. 13 WARD)

2-FULL NAME Ethel M. Merson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 3614 Rail Road av St.; yrs. 2 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widowed* (Write the word.)

6-DATE OF BIRTH, October 28, 1918 (Month) (Day) (Year)

7-AGE, 1 yrs. 9 mos. 8 ds. 8-LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Infantry* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), 3614 Rail Road Ave

10-NAME OF FATHER, John Isaac Merson

11-BIRTHPLACE OF FATHER, (State or Country), Laurel Md

12-MAIDEN NAME OF MOTHER, Ethel M. Creswell

13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Creswell

(Address) 3614 Rail Road

15-

JUN 7 - 1920

ROBERT B. ELLIOTT

Baltimore Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 5th, 1920 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from June 3, 1920, to June 5, 1920, that I saw her alive on June 5, 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY... Pneumonia (Secondary)

(Duration) yrs. 10 mos. ds.

(Signed) S. R. Watts M. D.

June 5, 1920 (Address) 865 W 30"

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

Laurel Md

DATE OF BURIAL,

June 7, 1920

20-UNDERTAKER

Chenoweth & Son Chestnut

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43801

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43801

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *5 Cottage Ave* ST. *27* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Emma Weir*(a) RESIDENCE. NO. *5 Cottage* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *6. 5. 1920*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or *6 hrs.*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)10 NAME OF FATHER *Wellington Weir*11 BIRTHPLACE OF FATHER (city or town) *Baltimore City* (State or country)12 MAIDEN NAME OF MOTHER *Helen King*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country)

14

Informant (Address) *Wellington Weir 5 Cottage Ave*

15

Filed *JUN 7 1920*

ROBERT A. KRAUTER

Registrar

Serial Permit 01001

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *6. 6. 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*June 5, 1920, to June 5, 1920,*that I last saw her alive on *June 5, 1920,*and that death occurred, on the date stated above, at *2:45 a.m.*

The CAUSE OF DEATH* was as follows:

Premature Labor, over distension of uterus due to multiple pregnancy(duration) *6 1/2 months* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *—* Date of *—*Was there an autopsy? *—*What test confirmed diagnosis? *—*(Signed) *C. H. Beeton* M. D., 19 (Address) *212 Washington*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*David Ridge**June 7 1920*

20 UNDERTAKER

Geo W Little

ADDRESS

521 1/2 ...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D43802

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43802

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 Cottage Ave ST.: 27 WARD)2-FULL NAME Helen Weis(a) RESIDENCE. No. 5 Cottage Ave

ST.: _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) _____5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____6 DATE OF BIRTH (month, day, and year) 6. 8. 20

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, 6 hrs. or min. _____

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Baltimore
(State or country)10 NAME OF FATHER Wellington Weis11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)12 MAIDEN NAME OF MOTHER Helen King13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)14 Informant Wellington Weis
(Address) 5 Cottage Ave15 Filed JUN 7 1920 ROBERT R. KRAUTH
Registrar

Burial Final Clerk

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6. 6. 192017 I HEREBY CERTIFY, That I attended deceased from June 5, 1920, to June 5, 1920, that I last saw her alive on June 5, 1920, and that death occurred, on the date stated above, at 3.15 a.m.

The CAUSE OF DEATH* was as follows:

Premature labor over distension of uterus due to multiple pregnancy
(duration) yrs. 6 1/2 mos. fortn

CONTRIBUTORY (Secondary) _____

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? — Date of _____Was there an autopsy? —What test confirmed diagnosis? —(Signed) C. H. Beeton M. D., 19 (Address) 2011 Washington Ave, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

David RidgeJune 7 1920

20 UNDERTAKER

Geo W Little

ADDRESS

531 N. ...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43803

D43803

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1019 S. Robinson* ST.: *1* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary E. Watworth(a) RESIDENCE. NO. *1019 S. Robinson* ST.: _____ WARD: _____
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *47* yrs. *3* mos. *24* ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Widowed*5a If ~~married~~ widowed, or divorced

(or) WIFE of

Edward Watworth

6 DATE OF BIRTH (month, day, and year)

Feb 11, 1873.

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*47**3**24*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Charles Weitzel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Harford Co. Md.

12 MAIDEN NAME OF MOTHER

Georganna Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ellicott City, Md.

14

Informant (Address)

Georganna Weitzel 1019 S. Robinson St.

15

JUN 7 - 1920

ROBERT A. KAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 5 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*May 28 1920 to June 5 1920*that I last saw her alive on *June 5 1920*and that death occurred, on the date stated above, at *5:30 A.* m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(duration) yrs. *6* mos. ds.

CONTRIBUTORY (Secondary)

Labur Pneumonia(duration) yrs. mos. *15* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Observation*(Signed) *H. B. Titlow* M. D.S. 1920 Address *2921 Odumell St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt. Carmel Cemetery**June 8 1920*

20 UNDERTAKER

ADDRESS

*Zirkler + Zirkler**1739 E. Eager St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43804

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43804

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hosp.* ST. *11* WARD)

2-FULL NAME

Charles W. Robinson(a) RESIDENCE. NO. *White Marsh Ind.*

(Usual place of abode)

WARD. *White Marsh Ind.*

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *life* yrs. mos. ds.How long in U. S., if of foreign birth? *life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*White*5 Single, Married, Widowed,
or Divorced (write the word)*Married*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Mary C. Robinson*

6 DATE OF BIRTH (month, day, and year)

March 5th 1871

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*49**3**-*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Clerk*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

*Br. C. R. R. Md.*9 BIRTHPLACE (city or town)
(State or country)*Perry Hall Md.*

10 NAME OF FATHER

James B. Robinson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Ellen E. Bond

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

PARENTS

14

Informant
(Address)*Mary C. Robinson*
White Marsh Md.

15

Filed

*JUN 7 - 1920**ROBERT H. KRATZER**Sanial Permit Clerk*

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 5 1920

17

HEREBY CERTIFY, That I attended deceased from
May 17 1920, to *June 5 1920*

that I last saw him alive on

*June 5 1920*and that death occurred, on the date stated above, at *6:35 A.M.*

The CAUSE OF DEATH* was as follows:

Chronic Cholelithiasis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Ac. Cordiac Dilatation*

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Home

Did an operation precede death?

*Yes*Date of *June 1st 1920*

Was there an autopsy?

No

What test confirmed diagnosis?

Op. & Symptoms

(Signed)

William B. Dallon

M. D.

, 19

(Address)

*Maryland General Hosp.**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Ebenezer Cemetery**June 8 1920*

20 UNDERTAKER

ADDRESS

Frank Lissachman Sons

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43805

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Biddle & Sellman Sanitarium*)

2-FULL NAME

Edmund B. Masterton

(a) RESIDENCE. NO.

2768 Fenwick Ave. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

*Widowed*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*the late Edith E. Masterton*

6 DATE OF BIRTH (month, day, and year)

Don't know

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

68

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Officer in Bank*(b) General nature of industry,
business, or establishment in
which employed (or employer)*086*

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Maine*

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER (city or town)

Don't know

(State or country)

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town)

Don't know

(State or country)

14

Informant
(Address)*Wesley L. Silverwood
2768 Fenwick Ave.*

15

Filed

*JUN 7 - 1920**ROBERT E. KADDER**Burial Permit Office*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 6* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

May 1, 19*19*, to *June 6*, 19*20*.that I last saw him alive on *June 5*, 19*20*.and that death occurred, on the date stated above, at *430* a.m.

The CAUSE OF DEATH* was as follows:

*Macromia Præcox Hypertrophy
and Stenosis of Mitral*

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Pyloric*

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *yes* Date of *June 2 1920*Was there an autopsy? *No*What test confirmed diagnosis? *Urinal analysis*(Signed) *George E. Hough*, M. D.19 (Address) *212 W. Madison St.**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Lund Ridge

DATE OF BURIAL

June 8 19*20*

20 UNDERTAKER

William Cook

ADDRESS

*502 E. North
Ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43806

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: WARD)

2-FULL NAME

(a) RESIDENCE. NO.

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred X yrs. 8 mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed JUN 7 1920

Robert A. Krauter

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

June 1, 1920, to June 5, 1920,

that I last saw him alive on

and that death occurred, on the date stated above, at 12:40 P.M.

The CAUSE OF DEATH* was as follows:

exhaustion

CONTRIBUTORY (Secondary)

(duration) X yrs. X mos. X 2 ds.

(duration) X yrs. X mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. K. Thomas, M. D.

(Address) 248 So. 34th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus Cem.

June 7, 1920

20 UNDERTAKER

ADDRESS

J. Herwig & Co.

2005 Alcan

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43807

CERTIFICATE OF DEATH.

D43807

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 H. Wolfe

ST.: 7

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1027 H. Wolfe

St.: 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

col.

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

widow

6-DATE OF BIRTH.

?

(Month)

(Day)

(Year)

7-AGE.

28

?

?

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

housewife
D. M. M. M.9-BIRTHPLACE,
(State or Country),

Va

10-NAME OF FATHER,

Ruben Stokes

11-BIRTHPLACE OF FATHER

(State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Lila Oliver

13-BIRTHPLACE OF MOTHER

(State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Stokes

(Address)

911 Rutland Ave

15-

Filed

JUN 7 - 1920

191

ROBERT E. KAUTER

Registrar

Social Filing Office

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from

18 April 1920, to June 1920.

that I saw her alive on " u 1920

and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Duration 2 1/2 yrs. 1 mos. ds.

CONTRIBUTORY
(Secondary)

Tuberculosis

(Duration) yrs. mos. ds.

(Signed) J. H. H. H. M. D.

June 1920 (Address) 475 N. D. D. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Richmond Va.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Richmond Va June 7, 1920.

20-UNDERTAKER

Chas G Bailey

ADDRESS

Jefferson St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43808

CERTIFICATE OF DEATH.

79✓ D43808

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 420 East Eager St. 10

2-FULL NAME

(Residence in Baltimore: No. 420 East Eager

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUN 7 - 1920

ROBERT E. KRAUTER

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry, find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

fat. dy heart

Contributory (Secondary)

(Signed) W. J. Riley (Coroner.)

June 7, 1920 (Address) 1039 Beverly

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS

Longwood Park, June 9, 1920

William Cook, 5026 North Ave

Laura G. Bailey HEALTH DEPARTMENT—CITY OF BALTIMORE

D43809

CERTIFICATE OF DEATH.

79✓
REGISTERED NO. C

D43809

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 2024 Mrs Culloh ST. 14 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

L. V. Bailey
(Residence in Baltimore: No. 2024 Mrs Culloh St. 65 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Cul

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
widow

6-DATE OF BIRTH,

May 28, 1853
(Month) (Day) (Year)

7-AGE,

65 yrs. 8 mos. ds.

If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE, (State or Country),

Ind

10-NAME OF FATHER,

Joseph Jones

11-BIRTHPLACE OF FATHER (State or Country),

Ind

12-MAIDEN NAME OF MOTHER

Ludiana Thompson

13-BIRTHPLACE OF MOTHER (State or Country),

Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUN 7 - 1920

ROBERT E. KLAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 5, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 1, 1920, to June 4, 1920,

that I saw him alive on June 4, 1920,

and that death occurred, on the date stated above, at 11:39 a.m.

The CAUSE OF DEATH* was as follows:

Valvular heart lesion

(Duration).....yrs. 5 mos.ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.mos.ds.

(Signed) W. J. Coleman M. D.

June 5, 1920 (Address) 2039 Mrs Culloh

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs.mos.ds. State yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Daniel Green

6/8/20, 191...

20-UNDERTAKER

ADDRESS

Thos. White

1138 Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43810

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

35 D43810
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 351 Yale Ave

ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Catherine Preston

(Residence in Baltimore: No. 451 Yale Ave

St.; yrs. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Apr 16, 1920
(Month) (Day) (Year)

7-AGE,

1 yr. 1 mos. 22 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), Balto.

10-NAME OF FATHER,

Bernard J. Preston

11-BIRTHPLACE OF FATHER

(State or Country), Balto.

12-MAIDEN NAME OF MOTHER

Anna Belle Roman

13-BIRTHPLACE OF MOTHER

(State or Country), Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bernard J. Preston

(Address) 451 Yale Ave

15-

JUN 7 - 1920

ROBERT E. KRAUTER

191 Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 7, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 10, 1920, to June 7, 1920,

that I saw her alive on June 6, 1920,

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) yrs. 3 mos. 22 ds.

CONTRIBUTORY General tuberculosis

(Secondary) (Duration) yrs. 53 ds.

(Signed) M. B. Roman and Hood M. D.

June 7, 1920, 1920. (Address) 636 N. Gilman St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral Cemetery

DATE OF BURIAL,

June 7, 1920

20-UNDERTAKER

Margaret E. Flynn Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43811

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

REGISTERED NO.

D43811

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1727 E Ball's St ST.: _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

4 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 2/1920

7 AGE

Years

Months

Days

If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Ind

10 NAME OF FATHER

Avron Shub

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Hospital Records

15

Filed

JUN 7 - 1920

ROBERT E. KAUTER

Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 6 1920

17

I HEREBY CERTIFY, That I attended deceased from June 2, 1920, to June 6, 1920, that I last saw him alive on June 6, 1920, and that death occurred, on the date stated above, at 10:30 a.m.
The CAUSE OF DEATH* was as follows:Asphyxia neonatorum

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Daniel Kauter, M. D.

19 (Address)

St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Workmen Circle New Mt Laurel 6-7-1920

20 UNDERTAKER

ADDRESS

Jack Lewis 1411 E. Balco

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43812

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43812

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Helen Hospital* ST. 6

WARD)

2-FULL NAME *Lila Huneycatt*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *209 W. Ellwood* - St. 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *Nov. 1898*

(Month)

(Day)

(Year)

7-AGE, *21* yrs. *6* mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *S.C.*10-NAME OF FATHER, *William A. Galloway*11-BIRTHPLACE OF FATHER (State or Country), *S.C.*12-MAIDEN NAME OF MOTHER, *Della Davis*13-BIRTHPLACE OF MOTHER (State or Country), *S.C.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm A Galloway*(Address) *209 W. Ellwood*

15-

Robert P. Harrison,

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 7, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquest* (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by gunshot

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Wm A Galloway* D.(Coroner) *Wm A Galloway*6-7, 1920 Address *209 W. Ellwood*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, *Rock Hill, South Baltimore*DATE OF BURIAL, *6/7, 1920*20-UNDERTAKER *J. G. Moran*ADDRESS *3000 E. Baltimore*

JUN 11 1920

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43813

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

6-091 D43813

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1407 Roman ST. 74 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth E. Seyfer

(Residence in Baltimore: No. 1407 Roman St.; 1 yrs. 3 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE Single
~~MARRIED~~
~~WIDOWED~~
~~OR DIVORCED~~
(Write the word)

6-DATE OF BIRTH June 6, 1920
(Month) (Day) (Year)

7-AGE 1 yrs. 3 mos. 14 ds. If LESS than 1 day, hrs., min.?

8-OCCUPATION (a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant

9-BIRTHPLACE (State or country) Baltimore Md.

10-NAME OF FATHER William P. Seyfer

11-BIRTHPLACE OF FATHER (State or country) Balto. Md.

12-MAIDEN NAME OF MOTHER Margaret McNeill

13-BIRTHPLACE OF MOTHER (State or country) Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Margaret E. Seyfer

(Address) 1407 Roman St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 6, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 22, 1920, to June 6, 1920, that I saw her alive on June 5, 1920, and that death occurred, on the date stated above, at 3:52 a.m.
The CAUSE OF DEATH* was as follows:

Measles
(as no informant)

(Duration) yrs. mos. 22 ds.

Contributory (SECONDARY) Broncho-pneumonia

(Duration) yrs. mos. 12 ds.

(Signed) Robert P. Harrison M. D.
June 7, 1920 [Address] 1216 E. Preston St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Funeral Home 8/8, 1920

20-UNDERTAKER ADDRESS

Funeral Home 1318 E. Light St.

21- Robert P. Harrison;
Burial Permit Clerk REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43812

D43812

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.:

WARD) 14

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada Jones(a) RESIDENCE. No. 1712 Etting
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18857 AGE Years Months Days If LESS than 1 day, hrs. or min.
35

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Elliott City
(State or country)10 NAME OF FATHER John Hall11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)12 MAIDEN NAME OF MOTHER Ann Jackson13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)14 Informant Hospital Records
(Address) New City Hospital.15 Filed Robert P. Harrison, Registrar
19 June 7 - 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6, 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 3, 1920 to June 6, 1920.that I last saw him alive on June 6, 1920.and that death occurred, on the date stated above, at 2:15 P.m.

The CAUSE OF DEATH* was as follows:

Lung Abscess & Gangrene(duration) yrs. 2 mos. ds.CONTRIBUTORY Purulent Pericarditis
(Secondary)unknown (duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?unknownDid an operation precede death? No Date ofWas there an autopsy? yesWhat test confirmed diagnosis? No special test(Signed) J. P. Pessel, M. D.19 PLACE OF BURIAL, CREMATION OR REMOVAL New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New City Hospital.20 UNDERTAKER Daniel Easton ADDRESS 916DATE OF BURIAL June 9, 1920

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43815

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43815

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 Vine ST.: 4 WARD)

2-FULL NAME

William Wells

(a) RESIDENCE. No.

705 Vine

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 21 4 COLOR OR RACE Col. 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Myrtle Wells

6 DATE OF BIRTH (month, day, and year)

7 AGE 21 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

general

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md

10 NAME OF FATHER

James Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md

12 MAIDEN NAME OF MOTHER

Elanor King

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md

PARENTS

14 Informant (Address)

James Wells
705 Vine St.

15

Filed Robert P. Harrison, 19

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

28

WARD

WARD.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 19 20

17

I HEREBY CERTIFY, That I attended deceased from May 26, 1920, to June 4, 1920 that I last saw him alive on June 3, 1920 and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia pulmonalis

CONTRIBUTORY (Secondary)

Pulmonary congestion

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

Signed Robert P. Harrison M. D. (Address) 1520 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Luke's Church

June 7 1920

20 UNDERTAKER

ADDRESS

Daniel E. Taylor

D43816

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43816

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2023 Eagle ST.: 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Nowack(a) RESIDENCE. NO. 2023 Eagle ST.: _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 19 19587 AGE Years Months Days If LESS than 1 day, hrs. or min. 61 5 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bermy10 NAME OF FATHER John Klahn11 BIRTHPLACE OF FATHER (city or town) (State or country) Bermy12 MAIDEN NAME OF MOTHER Mrs. Klahn13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bermy

14

Informant Mrs. Nowack (Address) 2023 Eagle St.

15

Robert P. Harrison

Registrar

JUN 7 - 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/5/192017 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1920, to 6/5/1920, that I last saw him alive on 6/5/1920, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency(duration) yrs. 6 mos. ds.CONTRIBUTORY (Secondary) Heart failure(duration) yrs. mos. 2 ds.18 Where was disease contracted if not at place of death? ✓Did an operation precede death? no Date of _____Was there an autopsy? ✓What test confirmed diagnosis? ✓(Signed) Harry Goldberry M. D.4/7, 1920 Address 2210 Fulton Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London ParkJune 5 1920

20 UNDERTAKER

ADDRESS

John P. Filds 1200 W. Lombard

D43817

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43817

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4738 Corn Heights Ln ST.; 27 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 4738 Corn Heights Ln St.; 27 yrs., 2 mos., 0 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH

April 6th, 1836 (Month) (Day) (Year)

7-AGE,

84 yrs., 2 mos., 0 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Ind.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,
Filed 7-19-191, 191

Registrar.

Marial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 6th, 1980 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Nov. 26th 1919, to June 6th 1980,that I saw her alive on June 6th 1980,and that death occurred, on the date stated above, at 9:10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial
Nephritis
(Duration) 2 yrs., 0 mos., 0 ds.

CONTRIBUTORY (Secondary)

(Duration) 0 yrs., 0 mos., 0 ds.(Signed) W. H. Harrison M. D.June 6th 1980 (Address) 401 E. 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

Carroll Chapel June 8th, 1980

20-UNDERTAKER

ADDRESS

William Cook 502 S. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43818

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43818

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital 22* WARD)REGISTERED NO.
(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

2-FULL NAME

(a) RESIDENCE. NO. *623 W. Lee* ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)Length of residence in city or town where death occurred *34* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed,
or Divorced (write the word) *single*5a If married, widowed, or divorced
HUSBAND of *=*
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *1866*7 AGE *about 54* Years Months Days If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work *L. W. 000*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) *Baltimore Md*10 NAME OF FATHER *George Pecht*11 BIRTHPLACE OF FATHER (city or town)
(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Anna Deibel*13 BIRTHPLACE OF MOTHER (city or town)
(State or country) *Germany*

14

Informant
(Address) *Robert P. Harrison,*
623 W. Lee St

JUN 7 - 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June - 5 1920*

17

I HEREBY CERTIFY, That I attended deceased from

May 17, 1920, to *June 5*, 1920.that I last saw her alive on *June 5*, 1920,and that death occurred, on the date stated above, at *2:30 A.M.*

The CAUSE OF DEATH* was as follows:

Præmie coma
(secondary to acceding pyelitis)(duration) yrs. mos. ds. *2 ds.*CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? *Home*Did an operation precede death? *yes* Date of *28th May*

Was there an autopsy?

What test confirmed diagnosis? *Symptoms*(Signed) *R. W. Wilson* M. D., 19 (Address) *18 E. Preston St**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**June 8 1920*

20 UNDERTAKER

W. G. H. Smith

ADDRESS

North St

D43819

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43819

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Franklin Dg. Hospital

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Marcus C. Wilson

(a) RESIDENCE. NO.

1321 N. Bond.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

5

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

Male White Married

5a If married, widowed, or divorced -

HUSBAND of
(or) WIFE of

Cecilia Wilson

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

Born 68 - - -

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Keeper

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Sparrows

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Wilmington
Del.

10 NAME OF FATHER

Marcus Wilson

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Delaware

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Unknown

14

Informant
(Address)Cecilia Wilson
321 N Bond St

JUN 7 - 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 6 - 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 31, 1920, to June 6, 1920,

that I last saw him alive on June 6 - 1920,

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Gangrene R. foot.

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? yes Date of June 3/20

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Newton S. Parr, M. D.

, 19 (Address) Franklin Dg. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park

June 9 1920

20 UNDERTAKER

ADDRESS

H. Beckwith

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43820

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43820

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3409 Guyton Oak* ST. *28* WARD)

2-FULL NAME

Annice Griffithh Nickolson

(a) RESIDENCE. NO.

3409 Guyton Oak ST. *28* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Lifetime ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE

Harry Grant Nickolson

6 DATE OF BIRTH (month, day, and year)

Nov 10 - 1865

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54

6

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto City Md

10 NAME OF FATHER

Walter A. Orona

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Emely Griffithh

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Rock Hall Md

14

Informant (Address)

Mrs Alice Miller 3409 Guyton Oak ave

15

Filed

19

Robert P. Harrison

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from

Feb 11, 19*19*, to *June 6*, 19*20*,

that I last saw him alive on *June 6*, 19*20*,

and that death occurred, on the date stated above, at *2 P* m.

The CAUSE OF DEATH* was as follows:

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Goodfayn Cw

June 8 19*20*

20 UNDERTAKER

ADDRESS

J. J. Schmitt

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43821

CERTIFICATE OF DEATH.

D43821

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1522 Bolton Street ST.; 14 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 1522 Bolton Street St.; 29 yrs., 11 mos., 16 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED, Widowed
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

June 15, 1820
(Month) (Day) (Year)

7-AGE,

99 yrs., 11 mos., 21 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).....
0009-BIRTHPLACE,
(State or Country),Piscataway, Prince Georges Co. Md.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Carmelita C. Edelen(Address) 1522 Bolton St. Balt., Md.

15-

Robert P. Harrison,
191.....
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 6, 1920
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from June 1 1920, to June 6 1920, that I saw her alive on June 6 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumo Pneumonia

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)Old age cardiac dilatation..... (Duration)..... yrs..... mos..... ds.(Signed) Robert C. Blake M. D.June 7, 1920 (Address) 1014 N. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Upper Marlboro Prince Georges Co.

DATE OF BURIAL,

20-UNDERTAKER

Henry H. Jenkins Sons

ADDRESS

McCallum & Oakley

Important. See instructions on back of certificate.

D43822

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D43822

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Bay View Hospital ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Butler

(a) RESIDENCE. NO.

653 Vine St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Bessie Butler (wife)

6 DATE OF BIRTH (month, day, and year)

Don't know '87

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

43

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country)

Baltimore Md.

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER (city or town). (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town). (State or country)

Md.

14

Informant (Address)

Hospital Recs. Bay View Hospital

15

JUN 8 - 1920

ROBERT E. KAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6/6/20

17

I HEREBY CERTIFY, That I attended deceased from

March 8, 1920 to June 6, 1920.

that I last saw him alive on June 6, 1920.

and that death occurred, on the date stated above, at 6:45 P. M.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

Septic Infection

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Crawford A. Hart M. D.

, 19 (Address) Bay View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn Cemetery June 10, 1920

20 UNDERTAKER

Mrs. Robt. A. Elliott, Ashland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 43823

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 521 S. Port St.: 1 WARD)
2-FULL NAME Baby Hennessey
(Residence in Baltimore: No. 521 S. Port St.; yrs., mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single
6-DATE OF BIRTH, June 6, 1920
(Month) (Day) (Year)

7-AGE, 1 yrs., 1 mos., 1 ds.
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto., Md.

10-NAME OF FATHER, Dan Pitipan

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Marie Hennessey

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Marie Hennessey
(Address) 521 S. Port St.

15-
Filed, 101, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 6, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Congenital Debility
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) [Signature] M. D.
(Coroner)
(Address) 1800 [Address]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity Cem. DATE OF BURIAL, June 8, 1920

20-UNDERTAKER, Peter Nicolaus ADDRESS, 2046 Eastern Ave.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43823

CERTIFICATE OF DEATH.

D4382

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 571 Port St.)

2-FULL NAME

(Residence in Baltimore: No. 571 Port St.)

REGISTERED No. C

(If death occur hospital or in give its NAME of street and num fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH,

7-AGE,

IF LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUN 8 - 1920

ROBERT E. KRAUTER

Bureau Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I took charge remains described above, held an inquest, autopsy or

thereon and from the evidence obtained by said

find that said deceased came to topsy or inquiry, on the day stated above.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos.

(Signed) (Coroner)

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, SIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos.

Where was disease contracted, if not at place of death

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BUR

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

D43824

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2535 Shirley Ave

ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2535 Shirley Ave

St.: 58 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH,

Aug. 4

1884 June

7-AGE,

45 yrs. 10 mos. 3 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

At home

9-BIRTHPLACE, (State or Country),

Virginia

10-NAME OF FATHER,

Thomas Charlton

11-BIRTHPLACE OF FATHER, (State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Ananda Gatchel

13-BIRTHPLACE OF MOTHER, (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Anne E. Kelly

(Address)

2535 Shirley Ave

ROBERT E. TRAISTER

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June

(Month)

6

(Day)

1920

(Year)

I HEREBY CERTIFY, That I attended deceased from 1919 to June 6, 1920.

that I saw her alive on June 6, 1920.

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma, internal of pelvis.

(Duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Signed) O. H. Hoffman M. D.

6-7-20 (Address) 100 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Green Mount June 7, 1920

20-UNDERTAKER

John O. Mitchell 1300 N. Fayette

IN 8-1920

D43825

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

130 D43825

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Wash*)ST. *27* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs. Maude Wächter

(a) RESIDENCE. NO.

5005 Harford Rd.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *39* yrs. *10* mos. *10* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Joseph J. Wächter*

6 DATE OF BIRTH (month, day, and year)

July 25, 1880

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*39**10**10*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Md.*

10 NAME OF FATHER

Harry J. Righ

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mary Plowing

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant
(Address)*Jos. J. Wächter
5005 Harford Rd.*

15

Filer

*JUN 8 - 1920**ROBERT E. LAUTER**Burial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*6/5*19*20*

17

I HEREBY CERTIFY, That I attended deceased from

*5/25*19*20*, to*6/5*19*20*that I last saw him alive on *6/5*, 19*20*and that death occurred, on the date stated above, at *8:15* a.m.

The CAUSE OF DEATH* was as follows:

*Prolonged Uterine
(Retained 5/26/20)*(duration) *10* yrs. mos. ds.CONTRIBUTORY
(Secondary)*Pulmonary Embolism*(duration) yrs. mos. *15 min*

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Yes

Date of

5/26/20

Was there an autopsy?

Yes

What test confirmed diagnosis?

(Signed)

L. W. D. R. R. R.

M. D.

6/5, 1920 (Address)*Mrs. Wash*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Balto Cem.**June 8, 1920*

20 UNDERTAKER

Philip Herwig

ADDRESS

*3016
Oleav*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D43826

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Sarah J. Noell

(Residence in Baltimore: No. 2654 H. Bender St.; 60 yrs., mos., ds.)

MEDICAL CERTIFICATE OF DEATH.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

August 9th, 1846
(Month) (Day) (Year)

73 yrs. 9 mos. 27 d.

**If LESS than 1 day,
....hrs. or....min.?**

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Housewife

9-BIRTHPLACE,
(State or Country).

10-NAME OF
FATHER,

**11-BIRTHPLACE
OF FATHER
(State or Country).**

**12-MAIDEN NAME
OF MOTHER**

**13-BIRTHPLACE
OF MOTHER
(State or Country).**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address)

15-

File #

BOOK REVIEW

Registrar.

16-DATE OF DEATH.

..... June 3, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
Feb. 5 1980, to June 5 1980,
that I saw her alive on June 5 1980,
and that death occurred, on the date stated above, at 8:40 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
& Hemiplegia
(Duration)..... yrs. mos. 2.4

CONTRIBUTORY... *Albert Selman*
(Secondary)

.....X (Duration).....yrs.....mos.....d.

(Signed) Edward J. Jones M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. da. In the State..... yrs. mos. da.

Where was disease contracted,
if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

1003/11 Ball's St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43827

CERTIFICATE OF DEATH.

D43827

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15 Filed

JUN 8 - 1920

ROBERT E. LEFOTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 24, 1920, to June 7, 1920

that I last saw him alive on June 7, 1920.

and that death occurred, on the date stated above, at 12:30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma face

CONTRIBUTORY
(Secondary)

(duration) 5 yrs. mos. ds.

(duration) 10 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) L. Clarence Cohn, M. D.

, 19 (Address) St. Agnes' Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Petersburg Va

6/8 1920

20 UNDERTAKER

ADDRESS

Chas. J. Evans & Son, 118 W. 1st St. Petersburg

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43828

CERTIFICATE OF DEATH.

X 138

D43828

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.: *4* WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Sarah E. Devese*

(a) RESIDENCE. NO. *Pikesville Md.* ST. _____ WARD. *Pikesville Md.*
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *2* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *William Devese*

6 DATE OF BIRTH (month, day, and year) *Jan. 23, 1889*

7 AGE Years *31* Months *4* Days *14* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer) *037*
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md.*

10 NAME OF FATHER *John Clarke*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*

12 MAIDEN NAME OF MOTHER *Sarah R. Pitts*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

14 Informant *Hospital Records*
(Address) *University Hospital*

15 Filed *JUN 8 - 1920* ROBERT R. KRAUTER Registrar
Burial Permit Class

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 6, 1920*

17 I HEREBY CERTIFY, That I attended deceased from *June 5*, 19*20*, to *June 6*, 19*20*, that I last saw her alive on *June 6*, 19*20*, and that death occurred, on the date stated above, at *1.05 A. M.*

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. *3* ds.

CONTRIBUTORY *Toxemia of Pregnancy*
(Secondary) (duration) yrs. *1* mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *yes*

What test confirmed diagnosis? *Autopsy findings*

(Signed) *J. A. Buchness*, M. D.

, 19 (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

David Ridge & Sons June 8 1920

20 UNDERTAKER ADDRESS

J. F. & Line Reisterstown Md

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43829

CERTIFICATE OF DEATH.

64 D43829

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3613 Elm Ave ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles W Wilhelm

(a) RESIDENCE. NO.

3613 Elm Ave

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary S Wilhelm

6 DATE OF BIRTH (month, day, and year)

June 6 1871

7 AGE

49

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

OWN

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind

10 NAME OF FATHER

John W Wilhelm

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind

12 MAIDEN NAME OF MOTHER

Alice Armacost

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind

14

Informant (Address)

Mary S Wilhelm
3613 Elm Ave

15

JUN 8 - 1920ROBERT F KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 7 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 4 1920 to June 7 1920that I last saw him alive on June 7 1920and that death occurred, on the date stated above, at 12:30 pm

The CAUSE OF DEATH* was as follows:

apoplexy

CONTRIBUTORY (Secondary)

acute nephritis
about 12 hours
about 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

S. R. Wautz
June 7/20
865 W 36th St

M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Marys Hospital
Chenoweth Son ChestnutJune 9 1920

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43830

CERTIFICATE OF DEATH.

29 D43830

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hillsdale* ST. *28* WARD)

2-FULL NAME *Elieha M'Kenzie*

(a) RESIDENCE. No. *Hillsdale*

(Usual place of abode)

ST. WARD.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred *49* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *married*

5a If married, widowed, or divorced HUSBAND of *None M'Kenzie* (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb 5-1871*

7 AGE Years *49* Months *4* Days *2* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Merchant*
(b) General nature of industry, business, or establishment in which employed (or employer) *Cotton Mill*
(c) Name of employer

9 BIRTHPLACE (city or town) *Ind* (State or country)

10 NAME OF FATHER *John M'Kenzie*

11 BIRTHPLACE OF FATHER (city or town) *Ind* (State or country)

12 MAIDEN NAME OF MOTHER *Jane Kelly*

13 BIRTHPLACE OF MOTHER (city or town) *Ind* (State or country)

14 Informant *None M'Kenzie* (Address) *Hillsdale*

15 Filed *JUN 8-1920* ROBERT E. LAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 7 1920*

17 I HEREBY CERTIFY, That I attended deceased from *Apr 11*, 1920, to *June 7*, 1920, that I last saw him alive on *June 6*, 1920, and that death occurred, on the date stated above, at *5 a* m. The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis
(duration) yrs. *4* mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) *A. F. Shiple* M. D.

6/7 1920 (Address) *Woodbury Ind*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Good Shepherd Cemetery *June 9 1920*

20 UNDERTAKER *Easton Sons* ADDRESS *Albert G*

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43831

CERTIFICATE OF DEATH

151 D43831
REGISTERED DOCT.

PLACE OF DEATH
CITY OF BALTIMORE (No. 1080 Granby ST. 3 WARD)
2-FULL NAME Annie Yankowsky
(Residence in Baltimore: No. 1080 Granby St. yrs. mos. 2 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
6-DATE OF BIRTH June 6, 1920
(Month) (Day) (Year)

7-AGE 2 yrs. 2 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

Baltimore Md.

PARENTS

10-NAME OF FATHER Joseph Yankowsky

11-BIRTHPLACE OF FATHER (State or country) Russia

12-MAIDEN NAME OF MOTHER Iulia Dainuka

13-BIRTHPLACE OF MOTHER (State or country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Yankowsky
(Address) 1080 Granby

15.

Filed JUN 8 - 1920

ROBERT E. LAUTER
REGISTRAR
Burial Permit 0122

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 8, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6, 1920 to June 8, 1920 that I saw him alive on June 7, 1920 and that death occurred, on the date stated above, at 10 a.m. The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Lewis A. Ephraim M. D.
June 8, 1920 (Address) 218 S. Exeter St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1st Evangelical

6/8, 1920

20-UNDERTAKER

ADDRESS

Robert Gialkowski

4280 Perry

D43832

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43832

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Thomas(a) RESIDENCE. NO. 1436 Carroll St.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Conrad Thomas11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Helen Green13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant Hospital Records
(Address) H. T. H.

15 JUN 8 - 1920

ROBERT H. BRANTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 4th, 1920, to June 5, 1920, that I last saw him alive on June 5, 1920, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

*Myocardial infarction
due to arteriosclerosis
coronaria*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *chronic mitral valvular disease* (duration) 10.7 yrs. mos. ds.18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George W. Williamson, M. D.6-5-20. 19 (Address) Municipal Tuberculosis Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Carmel Catholic 1920

20 UNDERTAKER

ADDRESS

Wm. J. L. Brown

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43833

CERTIFICATE OF DEATH.

137 D43833
REGISTERED NO. C1-PLACE OF DEATH *6.*CITY OF BALTIMORE: (No. *2324 Fairman Ave* St. *6* WARD)2-FULL NAME *Rena Myrta Eckhardt*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *2324 Fairman Ave* St. *35* yrs., *2* mos. *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *F*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *married*6-DATE OF BIRTH, *April 8, 1885*

(Month)

(Day)

(Year)

7-AGE, *35* yrs., *2* mos., *2* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *house wife*(b) General nature of industry, business, or establishment in which employed (or employer) *037*9-BIRTHPLACE, (State or Country), *Ba 14*10-NAME OF FATHER, *Charles F. Giesler*11-BIRTHPLACE OF FATHER (State or Country), *Ba 14*12-MAIDEN NAME OF MOTHER *Julia C. Thiemeyer*13-BIRTHPLACE OF MOTHER (State or Country), *Ba 14*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rena Eckhardt*(Address) *2324 Fairman Ave*

15-

Burial Permit Clerk

Filed *11/18/1920*

101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 7, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 31, 1920*, to *June 7, 1920*,that I saw her alive on *June 6, 1920*,and that death occurred, on the date stated above, at *8:00* m.

The CAUSE OF DEATH* was as follows:

Acute Bright's Kidney Disease(Duration) *8* yrs., *8* mos., *8* ds.

CONTRIBUTORY

(Secondary) *hypertension*(Duration) *8* yrs., *8* mos., *8* ds.(Signed) *A. B. Smith*

M. D.

6/7, 1920 (Address) *2324 Fairman Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *8* yrs., *8* mos., *8* ds. In the State *8* yrs., *8* mos., *8* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Woodlawn*DATE OF BURIAL, *June 9, 1920*20-UNDERTAKER *A. R. Jones*ADDRESS *2324 Fairman Ave*

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43834

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 7 Penn St

2-FULL NAME

David Warfield

(Residence in Baltimore: No. 7 Penn St,

ST.:

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Don't know, 1 (Month) (Day) (Year)

7-AGE,

42

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Laborn

9-BIRTHPLACE, (State or Country),

MS

10-NAME OF FATHER,

Rich Warfield

11-BIRTHPLACE OF FATHER (State or Country),

MS

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER (State or Country),

MS

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lizzia Wilson

(Address)

7 Penn St

15-

JUN 8 - 1920

191

ROBERT A. KRAUTER

REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 5, 1920 (Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, ay.

find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Don't know of any

(Duration) yrs. mos. ds.

(Signed) W. R. Gorman M. D. (Coroner.)

6-7, 1912 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn et

DATE OF BURIAL,

June 9, 1920

20-UNDERTAKER

J. H. Brown & Son

ADDRESS

108 W. Mounty

D43835

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43835

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2224 Orleans ST.: 6 WARD) 7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Leah Sherman

(a) RESIDENCE. NO.

2224 Orleans

ST.: _____ WARD. _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Life yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

15Jan

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Alb Sherman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Hannah Aaronson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Jack Lewis 1411 E. Boscawen St

15

Filed

JUN 8 - 1920ROBERT A. ELAUTE
RegistrarNot a Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 8th 1920

17

HEREBY CERTIFY, That I attended deceased from

May 30 1920, to June 8, 1920.that I last saw him alive on June 8, 1920.and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever.(duration) yrs. #6 mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Isaac M. Pusch, M. D.

, 19 (Address)

2352 Eastern Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Green Mt. CemeteryJune 8, 1920

20 UNDERTAKER

Jack Lewis1411 E. Boscawen St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43836

CERTIFICATE OF DEATH.

D43836

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 West Mulberry St., ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Moreton

(a) RESIDENCE. No. 117 West Mulberry ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23, 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Oakland, Carroll County, Maryland
(State or country)

10 NAME OF FATHER Samuel Moreton

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Kizia Hubbell

13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)14 Informant J. B. Harper
(Address) 345 North Calvert St.15 JUN 8 - 1920 ROBERT B. KRAUTER
Registrar
Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7th 1920

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1920, to June 7, 1920, that I last saw her alive on June 7, 1920, and that death occurred, on the date stated above, at 10:30 a.m. The CAUSE OF DEATH was as follows:

Senile Debility
(duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted at place of death
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. R. K. M. D.

19 (Address) Whitworth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Olivet Cemetery

DATE OF BURIAL

June 9, 1920

20 UNDERTAKER

Henry W. Mears & Son

ADDRESS

805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43837

CERTIFICATE OF DEATH.

64 D43837
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 N. Pulaski ST.; 70 WARD)

2-FULL NAME

(Residence in Baltimore: No. 303 N. Pulaski

St.; 68 yrs., 4 mos. 5 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

widow

6-DATE OF BIRTH,

Feb. 2, 1852
(Month) (Day) (Year)

7-AGE,

68 yrs., 4 mos. 5 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Kreutzer

(Address) 303 N. Pulaski

D761-8NOC

Filed 191

ROBERT H. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 7, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

off & on from 1915, to June 7, 1920,

that I saw her alive on June 6, 1920,

and that death occurred, on the date stated above, at 4²⁰ a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhages
(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Paralysis entire right side

(Duration) 5 yrs. ... mos. ... ds.

(Signed) Walter E. Truckenmiller M. D.

June 7, 1920 (Address) 2002 N. Lemay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Spk

UNDERTAKER

George Schwaab & Co

DATE OF BURIAL,

June 9, 1920

ADDRESS

2101 E. 11th Ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43838

D43838

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *St. Joseph's Hospital* ST.: *9* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *Brown* ST.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

13 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female white**single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 26-1920*

7 AGE

Years

Months

Days

If LESS than 1 day, ... hrs. or ... min.

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto ind*
(State or country)10 NAME OF FATHER *Robert N. Krueger*11 BIRTHPLACE OF FATHER (city or town) *Balto.*
(State or country) *Ind*12 MAIDEN NAME OF MOTHER *Bessie Golding*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore*
(State or country) *Ind*

14

Informant (Address) *Dr. J. V. ...*

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 8th 1920*

17

I HEREBY CERTIFY, That I attended deceased from

May 26, 19*20*, to *June 8*, 19*20*,that I last saw her alive on *June 7*, 19*20*,and that death occurred, on the date stated above, at *3:30* a.m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis(duration) yrs. mos. *1* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *phys. signs*(Signed) *J. V. ...* M. D., 19 (Address) *2021 Calvert St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Greenmount Cemetery**June 9th 1920*

20 UNDERTAKER

ADDRESS

*George Schilling & Sons**1126 E. ...*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

JUN 8 - 1920

Burial Permit Clerk.

D43839

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43839

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 806 N. Monford St. ST. 7 WARD)

2-FULL NAME

Anna H. Poole

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

806 N. Monford St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Herman H. Poole

6 DATE OF BIRTH (month, day, and year)

Oct 10, 1882

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

38 yrs

8

—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Germany

10 NAME OF FATHER

Louis Munzger

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Johanna Dine

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

(Address)

Herman H. Poole

806 N. Monford St.

JUN 8 - 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 6, 1920

17

I HEREBY CERTIFY, that I attended deceased from

april 19, 1920, to June 6, 1920,

that I last saw her alive on June 6, 1920,

and that death occurred, on the date stated above, at 8:20 m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus

(duration) yrs. mos. 2 ds.

CONTRIBUTOR

(Secondary)

Baroness Helen Blosser

Richard St.

(duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted

If not at place of death?

not known

Did an operation precede death? yes Date of April 1919

Was there an autopsy?

no

What test confirmed diagnosis?

Laboratory

(Signed)

R. B. Leeman

M. D.

(Address) 718 N. Pallman Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lenox Park Cemetery

June 9 1920

20 UNDERTAKER

Joe Jacobsen & Son

ADDRESS

217 S. B. Ave.

D43840

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43840

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1415 Madison Ave* ST.; *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1415 Madison Ave* St.; *31* yrs., *5* mos. *13* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Married*

6-DATE OF BIRTH,

Dec 23, 1889
(Month) (Day) (Year)

7-AGE,

*31 yrs. 5 mos. 13 ds.*If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, business, or establishment in which
employed (or employer).*Housewife*
*000*9-BIRTHPLACE,
(State or Country),*Balto Md*10-NAME OF
FATHER,*William B. Gill*11-BIRTHPLACE
OF FATHER
(State or Country),*Balto Co Md*12-MAIDEN NAME
OF MOTHER*Clara D. Piddicord*13-BIRTHPLACE
OF MOTHER
(State or Country),*Balto Co Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mr. Gill
1415 Madison Ave

15-

Robert P. Harrison,

Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 7, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

*Jan 12, 1920, to June 7, 1920,*that I saw her alive on *June 7, 1920,*and that death occurred, on the date stated above, at *3.50 p.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri(Duration) *1* yrs. *5* mos. *13* ds.CONTRIBUTORY
(Secondary)(Duration) *1* yrs. *5* mos. *13* ds.(Signed) *R. P. Harrison* M. D.*June 7, 1920* (Address) *1305 N. Patterson St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs. *5* mos. *13* ds. In the State *1* yrs. *5* mos. *13* ds.Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cath. Lawn June 9, 1920

20-UNDERTAKER

ADDRESS

W. J. DeKnecht *1415 Madison Ave*

important. See instructions on back of certificate.

JUN 8 1920

D43847

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43847

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs.

11 mos.

3 ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

JUN 8 - 1920

Filed

19

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-6-1920

17

I HEREBY CERTIFY, That I attended deceased from May 25th, 1920, to June 6th, 1920 that I last saw him alive on 6-6-20, 1920,

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 14 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) T. O. O'Shannon, M. D.

5/19/20 (Address) 423 E. Favre

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cem.

June 7 1920

20 UNDERTAKER

ADDRESS

W. S. Flynn

1422 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43842

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43842

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2750 Biggs Ave ST.; 16 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2750 Biggs Ave St.; 54 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Married
(Write the word.)

6-DATE OF BIRTH,

July 14, 1865
(Month) (Day) (Year)

7-AGE,

54 yrs., 10 mos., 18 ds.

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), Baltimore Md

10-NAME OF FATHER,

Martin Will

11-BIRTHPLACE OF FATHER

(State or Country), Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER

(State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Will(Address) 2750 Biggs Ave

15-

JUN 8 - 1920

Robert P. Harrison,

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 7, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

May 13 1920 to June 7 1920,
that I saw him alive on June 6 1920,
and that death occurred, on the date stated above, at 11 AM.

The CAUSE OF DEATH was as follows:

6 hours terminal heart failure

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. B. Haul M. D.(Address) 1929 N. Mount

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Western

DATE OF BURIAL,

June 10, 1920

20-UNDERTAKER

Geo W Little

ADDRESS

5314 Fremont Ave

important. See instructions on back of certificate.

Addicks S. Dorsey
HEALTH DEPARTMENT—CITY OF BALTIMORE

D43843

CERTIFICATE OF DEATH.

92 D43843
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *507 W. Cross* St.; *23* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Addicks Smother-Dorsey*(Residence in Baltimore: No. *507 W. Cross* St.; *1* yrs., *1* mos., *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Male</i>	4-COLOR OR RACE. <i>Colored</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>Single</i> (Write the word)
6-DATE OF BIRTH. <i>May 7, 1919</i> (Month) (Day) (Year)		
7-AGE. <i>1</i> yrs., <i>1</i> mos., <i>1</i> ds.		If LESS than 1 day,hrs. or....min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work..... <i>None</i> (b) General nature of industry, business, or establishment in which employed (or employer)..... <i>000</i>		

9-BIRTHPLACE,
(State or Country),
M.D.

PARENTS.	10-NAME OF FATHER, <i>Arthur Dorsey</i>
	11-BIRTHPLACE OF FATHER, (State or Country), <i>M.D.</i>
	12-MAIDEN NAME OF MOTHER <i>Mary Smother</i>
	13-BIRTHPLACE OF MOTHER (State or Country), <i>M.D.</i>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Smother*
(Address) *507 W. Cross St.*15-*JUN 9 - 1920*
Filed....., 191.....
ROBERT B. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,
June 7, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
June 1, 1920, to *June 7, 1920*,
that I saw him alive on *June 7, 1920*,
and that death occurred, on the date stated above, at *1:20 P.M.*

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration).....yrs.....mos.....*7*..ds.CONTRIBUTORY.....*As above*
(Secondary)(Signed).....*C. H. Flower*.....M. D.
June 8, 1920 (Address).....*712 S. Sharp St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

St. Andrew
June 9, 1920

20-UNDERTAKER

ADDRESS *1140**Brown & Ireland*
Schneider

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43847

CERTIFICATE OF DEATH.

D43847

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 1008 N. Lexington ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1008 N. Lexington St.; 39 yrs., 1 mos., 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. A. 4-COLOR OR RACE, Colored 5-SINGLE, married, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH, January 6, 1881
(Month) (Day) (Year)

7-AGE, 39 yrs., 1 mos., 1 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, House work
(b) General nature of industry, business, or establishment in which employed (or employer) 237

9-BIRTHPLACE, (State or Country), MD

10-NAME OF FATHER, Thomas Johnson

11-BIRTHPLACE OF FATHER (State or Country), MD

12-MAIDEN NAME OF MOTHER, Sant Thomas

13-BIRTHPLACE OF MOTHER (State or Country), MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lula Snowden(Address) 1008 N. Lexington St.

15-

Filed

JUN 9 - 1920

ROBERT B. KRAUTER

Burial Firm

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 6, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Saw her 191 May 26 191 20, that I saw her alive on May 26 191 20, and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
(Duration) 3 yrs., 1 mos., 1 ds.

CONTRIBUTORY. White pneumonia
(Secondary)

(Signed) James M. Snowden M. D.
191 20 (Address) 513 N. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Luke's June 8, 1920

20-UNDERTAKER

ADDRESS

Brown & Field Schroeder St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

41295
D43845

CERTIFICATE OF DEATH.

8-091
D43845
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST.: *19* WARD)2-FULL NAME *Herbert Hall*(a) RESIDENCE. NO. *317 S. Vincent St. Baltimore Md*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *Life* mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If nonresident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Caucas

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept. 9 - 1918*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1**8**29*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child jrd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *Herold Hall*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Urgie Wyatt*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland*

14

Informant (Address) *John Records*

15

Filed JUN 9 - 1920

ROBERT E. KRAUTER

Burial Permit 11871

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 7 1920*

17

I HEREBY CERTIFY, That I attended deceased from

June 2, 1920, to *June 7*, 1920,that I last saw him alive on *June 7*, 1920,and that death occurred, on the date stated above, at *11:30 a.m.*

The CAUSE OF DEATH* was as follows:

Pertussis(duration) — yrs. — mos. *14* ds.CONTRIBUTORY (Secondary) *Broncho pneumonia*(duration) *0* yrs. *6* mos. *6* ds.

18 Where was disease contracted

if not at place of death? *at home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *none*(Signed) *Harold L. Stiggins, M. D.*6/7, 1920 (Address) *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt Auburn Cem.**June 9 1920*

20 UNDERTAKER

ADDRESS

*A. Jones**207 S. Street*

CAUSE OF DEATH IN plain terms, so that it may be properly translated. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43846

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175

D43846

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Maryland General Hospital* St. *11* WARD)

2-FULL NAME

(Residence in Baltimore: No. *899 N. Howard St.* St. *6* yrs. *6* mos. *6* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

Unknown, 1914 (Month) (Day) (Year)

7-AGE,

6 yrs. *—* mos. *—* ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Student*
(b) General nature of industry, business, or establishment in which employed (or employer). *for*

9-BIRTHPLACE, (State or Country),

Balto. Md.

10-NAME OF FATHER,

Harry Blechman

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Leah Gordon

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jack Lewis*

(Address) *1411 E. Balto. St.*

15-

JUN 9 - 1920 *ROBERT E. KLAUTER* Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 8, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

opsy and that said deceased came to *his* death (Inquest, au-psy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

fractured skull
(auto-mob. accident.)
(Duration) *1* yrs. *—* mos. *—* ds.

CONTRIBUTORY (Secondary)

(Duration) *—* yrs. *—* mos. *—* ds.

(Signed) *J. A. Hennessy* M. D. (Coroner.)

June 8, 1920 (Address) *2802 Gunpowder Sq.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *Maryland Gen. Hosp.* In the of death *1* yrs. *—* mos. *—* ds. State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence *899 N. Howard St.*

19-PLACE OF BURIAL OR REMOVAL,

Greenwood

DATE OF BURIAL,

6-9-20

20-UNDERTAKER

Jack Lewis

ADDRESS

1411 E. Balto

D43847

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D43847

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 Lansing Ave ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Algus Thomas Holland(a) RESIDENCE. NO. 1708 Lansing Ave ST. 8 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofHannie Ford6 DATE OF BIRTH (month, day, and year) Oct 9-18827 AGE Years 37 Months 8 Days 29 If LESS than 1 day, 0 hrs. 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Motorman 078

(b) General nature of industry, business, or establishment in which employed (or employer)

United Railway

(c) Name of employer

9 BIRTHPLACE (city or town) Fairmount Md
(State or country)10 NAME OF FATHER James Holland11 BIRTHPLACE OF FATHER (city or town) Fairmount Md
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Fairmount Md
(State or country)

PARENTS

14 Informant Hannie Holland
(Address) 1708 Lansing Ave

15

JUN 9 - 1920 ROBERT E. LAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 192017 I HEREBY CERTIFY, That I attended deceased from 3 mos. ago (last time), to June 7, 1920,that I last saw him on June 6, 1920,
and that death occurred, on the date stated above, at 6:15 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosisabout 2 years (duration) 0 yrs. 0 mos. 0 ds.CONTRIBUTORY
(Secondary)(duration) 0 yrs. 0 mos. 0 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) W. J. Kelly, M. D.June 8, 1920 (Address) 1639 Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Fairmount MdJune 9 1920

20 UNDERTAKER

ADDRESS

J. Herwig & Co2008 Chas

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43848

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Richard M. Haffner

6 DATE OF BIRTH (month, day, and year)

Nov. 25, 1884

7 AGE

65

Months

6

Days

14

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sept. Drink Mfg.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Thos W. Haffner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Scotland

14

Informant (Address)

Richard M. Haffner
911. N. C. Haffner St.

15

Filed

JUN 9 - 1920

ROBERT E. KAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1920

17 I HEREBY CERTIFY, That I attended deceased from

May 15, 1920, to June 8, 1920,

that I last saw him alive on June 7, 1920,

and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

Chr. Interstitial Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course.

(Signed) Michael A. Abrams, M. D.

19 (Address) 2760 E. Howard place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lorraine Park

6-11-1920

20 UNDERTAKER

ADDRESS

Graham F. Walker

723 E. Howard

HEALTH DEPARTMENT—CITY OF BALTIMORE✓

D43850

CERTIFICATE OF DEATH.

64

D43850

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 Dolphin ST.: 17 WARD)2-FULL NAME Fannie J. Young(a) RESIDENCE. No. 609 Dolphin ST., 17 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? 1 yrs. 1 mos. 1 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Howard E. Young6 DATE OF BIRTH (month, day, and year) Sept 7-727 AGE Years 47 Months 47 Days 7 29 If LESS than 1 day, 29 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hunt co. Md
(State or country)10 NAME OF FATHER John H. Brown11 BIRTHPLACE OF FATHER (city or town) Kentucky
(State or country)12 MAIDEN NAME OF MOTHER Cora H. Epperson13 BIRTHPLACE OF MOTHER (city or town) Tenn.
(State or country)14 Informant Howard E. Young
(Address) 609 Dolphin St.15 JUN 9-1920 ROBERT H. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6/2017 I HEREBY CERTIFY, That I attended deceased from June 5, 1920, to June 6, 1920, that I last saw him alive on June 6, 1920, and that death occurred, on the date stated above, at 11:30 a.m.
The CAUSE OF DEATH* was as follows:Paralysis
(duration) yrs. mos. ds. 1
CONTRIBUTORY Cerebral hemorrhage
(Secondary) age (duration) yrs. mos. ds. 118 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? Physical(Signed) W. H. Thompson, M. D., 1920 Address) 1019 Smith Hill

*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

McArthur June 9 1920

20 UNDERTAKER ADDRESS

Sam H. Chase 1400 Market

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43851

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

645 N. Paca

ST.:

WARD)

REGISTERED NO. C

D43851

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Elijah N. Bell

(Residence in Baltimore: No.

645 N. Paca

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

M

4-COLOR OR RACE

Cal

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Mar

6-DATE OF BIRTH,

Dec

28, 1882

(Month)

(Day)

(Year)

7-AGE,

37 yrs. 4 mos. 10 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Md. Balt.

10-NAME OF FATHER,

Wilson Bell

11-BIRTHPLACE OF FATHER
(State or Country),

Md. Pa.

12-MAIDEN NAME OF MOTHER

Mary Brown

13-BIRTHPLACE OF MOTHER
(State or Country),

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

P. Rosa Bell

(Address)

645 N. Paca

15-

Filed

JUN 9 - 1920

ROBERT E. KRAUTER

BUTLER-PYRETH-CLARK

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

p. 7, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 30, 1920, to 6-7-20 191

that I saw him live on 6-6-20 191

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Scurvy

(Duration) yrs. mos. ds.

(Signed) M. D.

6-7-20, 191 (Address) 1524 1st St. S.W.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt. Auburn

June 10, 1920

20-UNDERTAKER

ADDRESS

Sam'l N. Chase

1400 N. Market

important. See instructions on back of certificate.

D43852

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D43852

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2023 Baltimore* ST. *20* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Teresa Aiken

(a) RESIDENCE. No.

2023 W Baltimore ST.

WARD.

20

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *6* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mr B Aiken

6 DATE OF BIRTH (month, day, and year)

June 29 1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*69**10**9*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Cumberland Md

10 NAME OF FATHER

James Nash Holvington

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Not known

12 MAIDEN NAME OF MOTHER

Catherine Garlan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Penna

14

Informant (Address)

George B Aiken 2023 W Baltimore

15

Filed

19

ROBERT E. KRAUTH

Registrar

JUN 9 - 1920

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 7th 1920

17

I HEREBY CERTIFY, That I attended deceased from *April 3rd 1920* to *June 8th 1920*, that I last saw her alive on *June 6th 1920*, and that death occurred, on the date stated above, at *10 AM* m.

The CAUSE OF DEATH* was as follows:

Uremic Coma(duration) yrs. mos. ds. *3*

CONTRIBUTORY (Secondary)

Ch. Nephritis(duration) yrs. mos. ds. *8*

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Bay M. Cleary M. D.

1920 (Address)

400 N Payson St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cathedral Cemetery**6/10 1920*

20 UNDERTAKER

ADDRESS

George & Parley Fulton & Son

D43853

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 Mc Elderry ST.; 7 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1514 Mc Elderry St.; yrs. mos. 12 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Black5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

May 28, 1920
(Month) (Day) (Year)

7-AGE.

yrs. mos. 12 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),Maryland

10-NAME OF FATHER,

Henry Walker11-BIRTHPLACE OF FATHER
(State or Country),Virginia

12-MAIDEN NAME OF MOTHER

Mary George13-BIRTHPLACE OF MOTHER
(State or Country),North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. T. [unclear](Address) Johns Hopkins Hospital

15-

Filed JUN 9 - 1920 191...

ROBERT B. KAUFMAN

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 28, 1920, to June 9, 1920,that I saw him alive on June 8, 1920,and that death occurred, on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) John W. Harrison M. D.619, 1910 (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Arbury

DATE OF BURIAL,

June 8, 1920

20-UNDERTAKER

John W. Henderson

ADDRESS

1502 E. Monument

important. See instructions on back of certificate.

D43854 HEALTH DEPARTMENT—CITY OF BALTIMORE D43854

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Warwick ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ester Virginia Bradley

(a) RESIDENCE. No. 1700 Warwick ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 22, 1920

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

None

9 BIRTHPLACE (city or town)
(State or country)

Balto Md

10 NAME OF FATHER

Irving K. Bradley

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Va.

12 MAIDEN NAME OF MOTHER

Elsie E. Engel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Balto Md

14

Informant
(Address)Mrs. Elsie E. Bradley
1700 Warwick Ave.

15

JUN 9 - 1920

ROBERT E. ELAUTER
Registrar

Burial Permit 0121

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 8th 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 22, 1920, to June 8, 1920,

(that I last saw him alive on June 5, 1920,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. C. Conser, M. D.

4/7, 1920 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western

June 9 - 1920

20 UNDERTAKER

ADDRESS

William Cook

502 E. Pratt

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43855

CERTIFICATE OF DEATH.

120
REGISTERED NO.

D43855

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3622 Roland Ave. ST.: 13 WARD)2-FULL NAME Sarah Catherine Bevans(a) RESIDENCE. NO. 3622 Roland Ave. 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)Length of residence in city or town where death occurred 32 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow6a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. X. Bevans6 DATE OF BIRTH (month, day, and year) March 18307 AGE Years 90 Months 3 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Del.10 NAME OF FATHER W. H. Hilsy11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Howard13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington14 Informant Howard X. Bevans
(Address) 3622 Roland Ave15 Filed 1920 ROBERT E. ELSTER
JUN 9 - 1920 Bureau Permit 01378

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1920

17

I HEREBY CERTIFY, That I attended deceased from

Jan 10, 1920, to June 8, 1920,that I last saw her alive on June 8, 1920,and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? ur. + B.P.(Signed) G. Woodward, M. D.6/9, 1920 Address 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London ParkJune 10 1920

20 UNDERTAKER

ADDRESS

Horace Burgee & Son3631 Falls Rd

CAUSE OF DEATH is very important. See instructions on back of certificates.

D43856

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43856

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4138 Roland Ave. ST. 13 WARD)

2-FULL NAME

Laura J. Miller(a) RESIDENCE. No. 4138 Roland Ave. ST. 13 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26-18667 AGE Years 54 Months 2 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Harford Co. Maryland

10 NAME OF FATHER

Benj. N. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Kent Co. Maryland

12 MAIDEN NAME OF MOTHER

Mary J. Nurnberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Harford Co. Maryland

14

Informant (Address)

Mrs. Margaret Miller
4138 Roland Ave.

15

Filed

JUN 9-1920ROBERT E. KAUTERRegistrar
Serial Permit 0518

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 192017 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to June 8, 1920, that I last saw her alive on June 1, 1920, and that death occurred, on the date stated above, at 12:00 A.M.
The CAUSE OF DEATH* was as follows:Carcinoma of Liver(duration) Indefinite mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

No operation

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Physician Exam.

(Signed)

C. H. Hayward, M. D.

1920

(Address) 2344 Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Perryman (Harford Co.) Md.June 10 1920

20 UNDERTAKER

Horace Burge Son

ADDRESS

663 Falls Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D43857

CERTIFICATE OF DEATH

REGISTERED No. C

D43857

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. *22*)

2-FULL NAME

(Residence in Baltimore: No. *106 Woodlawn Road*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; *89* yrs. *7* mos. *29* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at *12:40* m.

The CAUSE OF DEATH* was as follows:

(Duration) *5* yrs. *5* mos. *5* ds.

Contributory
(SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death *about* yrs. *0* mos. *14* ds. State *89* yrs. *7* mos. *29* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *106 Woodlawn Road Roland Park*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

JUN 9 - 1920

ROBERT A. KAUTER

REGISTRAR

REGISTRAR

(WILLIAM F. MOOREY, Successor)

108 W. NORTH AVE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43858

D43858

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Arundel Apts*)ST.: *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Louis Francis Young

(a) RESIDENCE. No.

Arundel Apts

ST.

WARD.

(Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

70 yrs. 5 mos. 14 ds.

How long in U. S., if of foreign birth?

70 yrs. 5 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Frances E. Young

6 DATE OF BIRTH (month, day, and year)

Dec. 23-1849

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*70**5**14*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sheet Metal Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

Sheet Metal Manufg

(c) Name of employer

(Self) Vaile & Young

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Christian J. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Anna L. Pippino

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Rev. C. M. Young - (brother) Washington D.C.

15

JUN 9 - 1920

ROBERT K. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 6 1920

17

I HEREBY CERTIFY, That I attended deceased from

*June 5, 1920, to June 6, 1920,*that I last saw him alive on *June 6, 1920,*and that death occurred, on the date stated above, at *11 20* m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris(duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *Wm. P. Lane* M. D.

6-8, 1920 (Address)

5-8 Proctor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Druid Ridge Cemetery**June 9 / 1920*

20 UNDERTAKER

STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43859

CERTIFICATE OF DEATH.

D43859

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 743 W. Saratoga St., ST.; 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Porpora

(Residence in Baltimore: No. 743 W. Saratoga St., St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Single

6-DATE OF BIRTH,

April.....23....., 1919.
(Month) (Day) (Year)

7-AGE,

One yrs. 1 mon. 15 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
Child

9-BIRTHPLACE,

(State or Country), Baltimore, Md.

10-NAME OF FATHER,

Joseph Porpora

11-BIRTHPLACE OF FATHER

(State or Country), Italy

12-MAIDEN NAME OF MOTHER

Grace Dalfonzo

13-BIRTHPLACE OF MOTHER

(State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Green

(Address) 1008 E. Pennsylvania Ave.

15-

JUN 9 - 1920 ROBERT A. KRAUTER

Filed....., 191.....

Burial Permit #11444

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 8th, 1920, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 3rd, 1920, to June 8th, 1920,

that I saw him alive on June 8th, 1920,

and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration).....yrs.....mos. 4.....ds.

CONTRIBUTORY.....Malaria.....
(Secondary)

(Duration).....yrs.....mos. 6.....ds.

(Signed) J. B. Cuthbertson M. D.

6/8/20, 191... (Address) 1800 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Cemetery

June 9, 1920

20-UNDERTAKER

ADDRESS

H. M. Routson

230 Greene

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D43860

CERTIFICATE OF DEATH.

81 D43860

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2030 N. Washington* ST.: *8* WARD)

2-FULL NAME

Charles Gantry

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

2030 N. Washington ST.: *8* WARD.

(Usual place of abode)

WARD.

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widower*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Catherine Gantry*6 DATE OF BIRTH (month, day, and year) *May 15-1853*7 AGE Years *87* Months *—* Days *22* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

Builder

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Pa.*

10 NAME OF FATHER

*Wm Gantry*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Pa*

12 MAIDEN NAME OF MOTHER

*Sarah Bose*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Pa*

14

Informant
(Address)*Daniel B. Gantry*
1754 E. North Ave

15

Filed

*JUN 9-1920**ROBERT H. REAUTER*

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 7* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

15 Sept, 19*18*, to *June 7*, 19*20*.that I last saw him alive on *June 7*, 19*20*.and that death occurred, on the date stated above, at *7.30 p.m.*

The CAUSE OF DEATH* was as follows:

Senile Arterio-Sclerosis(duration) *5* yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *W. C. Sandrock* M. D.7. V. 1920 (Address) *1242 N. Broadway.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Greenmount June 10 19*20*

20 UNDERTAKER

ADDRESS

H. C. Wiedefeld 914 Gunmit

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43861

CERTIFICATE OF DEATH.

REGISTERED NO.

D43861

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

63 yrs. 1 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male.

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Mary A. Gnaue

6 DATE OF BIRTH (month, day, and year)

April 21-1857

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

63

7

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Brokerman

(b) General nature of industry, business, or establishment in which employed (or employer)

J. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Ct.

10 NAME OF FATHER

John Gnaue

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Not Known

14

Informant
(Address)Mrs. Mary A. Gnaue
2614 Orleans St.

15

File

JUN 9 - 1920

ROBERT A. TRAUTER
Registrar

Burial Permit 0122

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 8 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 5, 1920, to June 7, 1920.

that I last saw him alive on June 7, 1920.

and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Acute thrombosis

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

3 yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

Geo. D. Draper

M. D.

, 19

(Address)

2818 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemed Cemetery

June 11 1920

20 UNDERTAKER

ADDRESS

Henry Horch Son

1301 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43863

CERTIFICATE OF DEATH.

120

D43863

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST.: *13* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Josephine Chandler*(a) RESIDENCE. No. *344* *Amesbury* ST.,WARD. *New York*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female**White**Married*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Chas. B. Chandler*

6 DATE OF BIRTH (month, day, and year)

April 7-1877

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*43**2**1*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*New York*

10 NAME OF FATHER

John Morgan

11 BIRTHPLACE OF FATHER (city or town)

N. Y.

(State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

Unknown

(State or country)

14

Informant
(Address)*J. H. Records*

15

File

JUN 9 - 1920

ROBERT B. KAUTER

Registrar

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 8* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

June 7, 19*20*, to *June 8*, 19*20*,that I last saw him alive on *June 8*, 19*20*,and that death occurred, on the date stated above, at *6:45* a. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis(duration) *2* yrs. *4* mos. *4* ds.CONTRIBUTORY
(Secondary)*uremia*(duration) *4* yrs. *4* mos. *4* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *John H. B. Kauter*, M. D., 19 (Address) *John H. B. Kauter*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Druid Ridge**June 10 1920*

20 UNDERTAKER

H. Sander Sons

ADDRESS

1710 Fleet St.

TIONS is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43864

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

42 D43864
REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME

(Residence in Baltimore: No.

Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

W

5 SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

1

27, 1862

(Month)

(Day)

(Year)

7 AGE

58

yrs.

4

mos.

10

ds.

If LESS than
1 day, hrs.
or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

037

9 BIRTHPLACE
(State or country)

Baltimore, Md.

PARENTS

10 NAME OF FATHER

Fredrick Schafer

11 BIRTHPLACE OF FATHER
(State or country)

Germany.

12 MAIDEN NAME OF MOTHER

Federicka Whitman

13 BIRTHPLACE OF MOTHER
(State or country)

Germany.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ernest P. West

(Address)

241 S. Ellwood Ave

15 JUN 9 - 1920

ROBERT R. KAUTER

Filed

191

BURIAL PERMIT STATE REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June

7

20, 1920

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 15, 1910, to June 7, 1920.

that I saw her alive on June 7, 1920.

and that death occurred, on the date stated above, at 11:25 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus
with metastasis.

(Duration)

yrs.

8

mos.

ds.

Contributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed),

Harry S. McCarty

M. D.

June 7, 1920

(Address)

37 W. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

St Pauls Cem.

DATE OF BURIAL

June 10, 1920

20 UNDERTAKER

H. Sander Son

ADDRESS

1410 Fleet St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43865

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2830 6 Clifton ST. 15 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2830 6 Clifton St. Life mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE, <u>White</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <u>Married</u>
6-DATE OF BIRTH, <u>Oct</u> <u>2</u> , <u>1874</u> (Month) (Day) (Year)		
7-AGE, <u>45</u> yrs. <u>8</u> mos. <u>5</u> ds. IF LESS than 1 day, hrs. or min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer)..... <u>None</u> <u>037</u>		
9-BIRTHPLACE, (State or Country), <u>Md.</u>		
PARENTS.	10-NAME OF FATHER, <u>Joseph L. Mullen</u>	
	11-BIRTHPLACE OF FATHER (State or Country), <u>Md.</u>	
	12-MAIDEN NAME OF MOTHER <u>Rebecca Shumway</u>	
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Balto</u>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. H. McNamee(Address) 4207 Fremont Ave

15-

Robert P. Harrison,
191.....

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 7, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1919, to June 7 1920,
that I saw her alive on June 7 1920,
and that death occurred, on the date stated above, at 6.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. Phthisis
(Duration) 2 yrs. mos. ds.CONTRIBUTORY
(Secondary) None(Signed) W. A. Kneel M. D.
6/7, 1920. (Address) Livingston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Important. See instructions on back of certificate.

JUN 9 - 1920

D43866

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43866

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 S. Payson ST.: 30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. Tarentum Pennsylvania ST.: Tarentum Pa.

(Usual place of abode)

WARD. Tarentum Pa.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

11 ds.

How long in U. S. if of foreign birth?

yrs.

mos.

11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OF RACE

Wht.

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

single

6 DATE OF BIRTH (month, day, and year)

Dec. 1876

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

44

5

—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Tarentum Pa

10 NAME OF FATHER

Jacob Unger

11 BIRTHPLACE OF FATHER (city or town)

Germany

(State or country)

12 MAIDEN NAME OF MOTHER

Anna E. Fuchs

13 BIRTHPLACE OF MOTHER (city or town)

Germany

(State or country)

14

Informant (Address)

Miss Rose A. Unger
Tarentum Pa

15

JUN 9 - 1920

Robert P. HARTMAN

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 9, 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 6, 1920, to June 9, 1920,

that I last saw her alive on June 8, 1920,

and that death occurred, on the date stated above, at 1045 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Etiology of disease

(duration) 16 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

James H. Hagerman M. D.
6/9, 1920 (Address) 1729 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Tarentum Pa June 9 1920

20 UNDERTAKER

ADDRESS

Geo. L. Schmitt & Bro 2101 Freds Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHOTODUPLICATION should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D43867

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D43867

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. 1 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Widowed*

6 DATE OF BIRTH April 28, 1920 (Month) (Day) (Year)

7 AGE yrs. 1 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) *000*

9 BIRTHPLACE (State or country) *Baltimore*

10 NAME OF FATHER *Cecil L. Anderson*

11 BIRTHPLACE OF FATHER (State or country) *Balto Co*

12 MAIDEN NAME OF MOTHER *Emma L. Munnich*

13 BIRTHPLACE OF MOTHER (State or country) *Baltimore City*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Cecil L. Anderson* (Address) *2747 Harlem Ave*

15. Robert P. Harrison, 191 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 8, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28, 1920, to June 8, 1920, that I saw her alive on June 8, 1920, and that death occurred, on the date stated above, at 2:45 P.M. The CAUSE OF DEATH* was as follows:

6 1/2 Months Premature Birth

(Duration) yrs. 1 mos. 11 ds. Contributory *Malnutrition* (SECONDARY) *Cardiac Disease*

(Signed) *Harbert E. Goffe* M. D. June 8, 1920 (Address) *3050 N. York Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Western Cemetery* DATE OF BURIAL *June 9, 1920*

20 UNDERTAKER *Geo. V. Schwalbe* ADDRESS *2101 Park Ave*

D43868

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43868

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

9 Dacfield Av. ST. 28 WARD)

2-FULL NAME

Baby Munder

(a) RESIDENCE. No.

9 Dacfield Av. ST. Arlington WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. If of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Mkt

5 Single, Married, Widowed,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 7/20

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md.

10 NAME OF FATHER

Geo. Munder

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Ger.

12 MAIDEN NAME OF MOTHER

Amalia Hoffman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Baltimore Md.

14

Informant
(Address)Mr Amalia Munder
9 Dacfield Av.

15

Registrar

Robert B. Harrison,

Registrar

Baptist Church Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 7th 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 7th, 1920, to June 7th, 1920,that I last saw him alive on June 7th, 1920,

and that death occurred, on the date stated above, at 6:45 P. M.

The CAUSE OF DEATH* was as follows:

Prematurity

5 mo foetus

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. J. Smith, M. D.

, 19 (Address) 1605 W North Av

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

JUN 9 1920

D43869

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43869

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hosp.*)ST.: *4*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Rev. F. S. Hulbert*(a) RESIDENCE. NO. *Hagerstown, Md.*

ST.,

WARD. *Hagerstown, Md.*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos. *19*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Nov. 13, 1878*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)10 NAME OF FATHER *Henry Hulbert*11 BIRTHPLACE OF FATHER (city or town)
(State or country)12 MAIDEN NAME OF MOTHER *Harriet Sykes*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 9* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

May 21, 19*20*, to *June 9*, 19*20*.that I last saw him alive on *June 9*, 19*20*.and that death occurred, on the date stated above, at *4:30* p. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Wm. D. Taylor, M. D.*49, 19 (Address) *Mary Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Hagerstown Md**6/9 20*

20 UNDERTAKER

ADDRESS

Chas. P. Waue & Son 11801st Royal

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

UN 9-1920

Burial Permit Clerk.

D43870

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43870

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

Mount Hope Remar

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ellie M. Flynn

(a) RESIDENCE. NO.

Hartford Corner -

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

1 yrs.

0 mos.

ds.

How long in U. S., if of foreign birth

250 yrs.

0 mos.

0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Not known

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Hartford Corner -

10 NAME OF FATHER

James Flynn

11 BIRTHPLACE OF FATHER (city or town) (State or country)

West Meade Ireland

12 MAIDEN NAME OF MOTHER

Margaret Coughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

West Meade Ireland -

14

Informant (Address)

Records of Mt Hope Remar
Mt Hope, Balto., Md.

JUN 9 - 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 9 1920

17

I HEREBY CERTIFY, That I attended deceased from:

June 11th, 1919, to June 9th, 1920.that I last saw her alive on June 8th, 1920.

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Paracystomatous Septicemia
with Acute Dilatation of Heart -
abs (duration) 2 yrs. 6 mos. 0 ds.CONTRIBUTORY Dementia Precox -
(Secondary)

Paranoid Type - (duration) 2 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Hartford Corner -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis -

(Signed) Frank J. Flannery M. D.

June 9th, 1920 (Address) Mt Hope Remar -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hartford Corner June 9/ 1920

20 UNDERTAKER
STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

D43871

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 Camel

ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Catharine Johnson*

(Residence in Baltimore: No. 221 Camel

St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

....., 1887

(Month)

(Day)

(Year)

7-AGE,

33 yrs. mos. ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

137

9-BIRTHPLACE, (State or Country)

Md.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country), *Md.*

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER

(State or Country), *Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James Easton*(Address) *716 Connaught*

15-

JUN 9 - 1920

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 8th, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 24, 1920, to June 8th, 1920,

that I saw her alive on June 8th, 1920,

and that death occurred, on the date stated above, at 6:30 p. m.

The CAUSE OF DEATH* was as follows:

*Pulmonary Consumption**About* (Duration).....yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs. 10 mos. ds.

(Signed) *Samuel A. Bain* M. D.June 9, 1920 (Address) *937 Madison*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. mos. ds. In the State.....yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Peter's *June 10, 1920*

20-UNDERTAKER

ADDRESS

James Easton *Connaught*

D43872

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43872

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1339 N. Fremont ST. 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daisy Gross(Residence in Baltimore: No. 1339 N. Fremont St.; 5 yrs., 5 mos., 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female4-COLOR OR RACE. Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH. March 23, 1907

(Month)

(Day)

(Year)

7-AGE, 13 yrs., 2 mos., 15 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ind.10-NAME OF FATHER, John T. Gross11-BIRTHPLACE OF FATHER (State or Country), Ind.12-MAIDEN NAME OF MOTHER Laura Marshall13-BIRTHPLACE OF MOTHER (State or Country), Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Smith(Address) 1339 N. Fremont St.

15-

Robert P. Harrison,

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 7, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from May 16, 1920, to June 7, 1920,that I saw her alive on June 6, 1920,and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(Duration)..... yrs. 5 mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed) J. S. Marshall M. D.June 7, 1920 (Address) 2336 Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Luke's CemeteryDATE OF BURIAL, June 12, 192020-UNDERTAKER Daniel E. CarterADDRESS Beuna Vista

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43873

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

D43873

1-PLACE OF DEATH

CITY OF BALTIMORE (No. South Balto. General Hospital) 24 WARD)

2-FULL NAME George E. Hess.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. Roanoke Va. St.: yrs., mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)

6-DATE OF BIRTH, Do not know, 1 (Month) (Day) (Year)

7-AGE, 45 yrs. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Cement contractor. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Martinsburg W. Va.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ronald R. Fairfax.

(Address) Homewood Apartments.

15- Robert P. Harrison, 101 Registrar.

JUN 9 - 1920

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 8th, 1920, 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the Skull. Accidentally struck by automobile # 15-809 H.

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Signature) Otto W. Remhardt M. D. (Coroner.)

June 9th, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death? Patapsco & 1st Sts. Brooklyn.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Roanoke Va. DATE OF BURIAL, June 10 1920

20-UNDERTAKER JOHN F. DENNY ADDRESS 715 LIGHT ST.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43874

CERTIFICATE OF DEATH.

37

D43874

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 133 1/2 N. Gilman ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M. Stacy(a) RESIDENCE. No. 133 1/2 N. Gilman ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

15 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child prod

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER Charles P. Stacy11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky12 MAIDEN NAME OF MOTHER Lucy F. Stacy13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14

Informant (Address) Lucy F. Stacy
133 1/2 N. Gilman St.

15

Filed JUN 10 1920ROBERT E. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 7, 1920, to June 9, 1920,
that I last saw him alive on June 9, 1920.and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage and Hemorrhage of the brain(duration) 1 yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary)

Congenital Syphilis
(duration) 1 yrs. 1 mos. 2 ds.

18 Where was disease contracted

If not at place of death?

During gestationDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Charles E. Clark, M. D.19, 1920 Address 1306 N. Gilman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lorraine Cem.June 10 1920

20 UNDERTAKER

Harry W. Ehler
W. North

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43875

CERTIFICATE OF DEATH.

79 D43875
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 S. Caroline ST.: 3 WARD)

2-FULL NAME

(a) RESIDENCE. No. 106 S. Caroline ST., WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Widow6 DATE OF BIRTH (month, day, and year) March7 AGE 47 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Na10 NAME OF FATHER John Tascoc11 BIRTHPLACE OF FATHER (city or town) (State or country) Na12 MAIDEN NAME OF MOTHER Mary Thomas13 BIRTHPLACE OF MOTHER (city or town) (State or country) Na14 Informant Lillian Robinson (Address) 106 S. Caroline St15 Filed JUN 10 1920 ROBERT A. KAUTER RegistrarBurial Permit 0122

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 192017 I HEREBY CERTIFY, That I attended deceased from June 1, 1920 to June 8, 1920that I last saw him alive on June 8, 1920and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baths mdDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? ClinicalSigned Dr. B. B. Brown M.D.(Address) 1520 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Asbury

DATE OF BURIAL

6/11/20 19

20 UNDERTAKER

John W. HendersonADDRESS 1502E. Monument

CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43876

CERTIFICATE OF DEATH.

79 D43876
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2930 Clifton Ave ST.; 15 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2930 Clifton Ave St.; 10 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male4-COLOR OR RACE, W.5-SINGLE, married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, Oct 15, 1863

(Month)

(Day)

(Year)

7-AGE, 56 yrs., 7 mos., ds.If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Bookkeeper(b) General nature of industry, business, or establishment in which employed (or employer), 0089-BIRTHPLACE, (State or Country), Port Deposit Md10-NAME OF FATHER, John J. Smith11-BIRTHPLACE OF FATHER (State or Country), Lancaster Pa12-MAIDEN NAME OF MOTHER, Mary Ingle13-BIRTHPLACE OF MOTHER (State or Country), Lancaster Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), McLanin Smith(Address), 2930 Clifton Ave

15-

Filed JUN 10 1920

BOBBY A KRAUTER

BUTLER PRINTING CO. REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 8, 1920

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from May 23, 1920, to June 8, 1920, that I saw him alive on June 8, 1920, and that death occurred, on the date stated above, at 8 m. The CAUSE OF DEATH* was as follows:Mitral Regurgitation(Duration) yrs., mos., ds.CONTRIBUTORY (Secondary), Coronary decomposition(Duration) yrs., mos., ds.(Signed), George W. SmithJune 8, 1920, (Address), 2935 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence 19-PLACE OF BURIAL OR REMOVAL, London ParkDATE OF BURIAL, June 10, 192020-UNDERTAKER, Geo J. SmithADDRESS, 1000 St. Fayette

important. See instructions on back of certificate.

D43877

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

30

D43877

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1932 E. Lombard ST.: 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Bach(a) RESIDENCE. NO. 1932 E. Lombard ST. 2 WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 10 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child6 DATE OF BIRTH (month, day, and year) July 17 19177 AGE Years 2 Months 10 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)10 NAME OF FATHER Lewis J. Bach11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)12 MAIDEN NAME OF MOTHER Margaret Pfeiffer13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)14 Informant Lewis J. Bach
(Address) 1932 E. Lombard St.15 JUN 10 1920 BOBBY F. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 192017 I HEREBY CERTIFY, that I attended deceased from May 26 1920 to June 8 1920that I last saw her alive on June 8 1920and that death occurred, on the date stated above, at 6:35 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis (Tubercular)(duration) about 14 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓Did an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? Smear, Prussian Blue
(Signed) Geo. Heller M. D.6-8, 1920 Address 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cem June 10 1920

20 UNDERTAKER

ADDRESS

Lilly & Zeller 403 S. Wolfe St

TION is very important. See instructions on back of certificates.

Pulley.
HEALTH DEPARTMENT—CITY OF BALTIMORE

D43878

CERTIFICATE OF DEATH.

D43878

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Preston ST.; 15 WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. 1416 Preston St.; 5 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *Col.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Widowed*
(Write the word.)

6-DATE OF BIRTH. *Aug. 6, 1886*
(Month) (Day) (Year)

7-AGE. *37* yrs., mos., ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *no paid occupation*
(b) General nature of industry, business, or establishment in which employed (or employer). *000*

9-BIRTHPLACE, (State or Country), *Ind.*

10-NAME OF FATHER, *George Pulley*

11-BIRTHPLACE OF FATHER (State or Country), *Ind.*

12-MAIDEN NAME OF MOTHER *not known*

13-BIRTHPLACE OF MOTHER (State or Country), *not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Chas H. Pulley*

(Address) *905 Whelan St.*

15-JUN 10 1920 ROBERT E. ERAUTER

Filed 191. *BALTIMORE* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 6, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 25, 1920*, to *June 6, 1920*, that I saw her alive on *June 5, 1920*, and that death occurred, on the date stated above, at *6 P. M.* The CAUSE OF DEATH* was as follows:

Paralysis - Hemiplegia
(Duration) *about 6 wks.* mos., ds.

CONTRIBUTORY (Secondary)

(Duration) *about 6 wks.* yrs., mos., ds.

(Signed) *T. S. Hemmell* M. D.

June 5, 1920 (Address) *1226 Madison St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *...* yrs., mos., ds. In the *...* State *...* yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Mt Auburn *June 10, 1920*

20-UNDERTAKER ADDRESS

Edward Ringgold *1463 N. Carey*

important. See instructions on back of certificate.

Cogley
HEALTH DEPARTMENT—CITY OF BALTIMORE

D43879

CERTIFICATE OF DEATH.

82 D43879
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 572 Enock

ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 572 Enock

(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

James Cogley

6 DATE OF BIRTH (month, day, and year)

April 3, 1874

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

76

2

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Penn

10 NAME OF FATHER

Peter Barrett

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

James H. Harkness

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Sofia Rode 572 Enock St.

15

Filed

JUN 10 1920

ROBERT A. FRASER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 9 1920

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1920, to June 9, 1920, that I last saw her alive on June 8, 1920, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

Exhaustion 7

(duration)

yrs.

mos.

ds.

2

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Physical diagnosis)

(Signed)

Adolph C. Eisenberg, M. D.

, 19

(Address) 2201-03 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Wm. Cook

A. G. Mc

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43880

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 S. Duncan ST.; 1 WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. 419 S. Duncan St.; 1 yrs., 3 mos., 14 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (If write the word.)

Single

6-DATE OF BIRTH.

Feb 24, 1919
(Month) (Day) (Year)

7-AGE.

1 yrs., 3 mos., 14 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE, (State or Country).

City

PARENTS.

10-NAME OF FATHER.

Mathew Connor

11-BIRTHPLACE OF FATHER (State or Country).

MA

12-MAIDEN NAME OF MOTHER

Estelle Franz

13-BIRTHPLACE OF MOTHER (State or Country).

MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mathew Connor(Address) 419 S. Duncan

15-

Filed

JUN 10 1920

ROBERT E. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 8, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 27 1920, to June 8 1920,

that I saw him alive on June 7 1920,

and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Acute Bronchitis

(Signed) E. A. Heller M. D.

6-9-1920 (Address) 1937 South St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Holy Redeemer June 10 1920

20-UNDERTAKER

Philip Henry Orleans St

important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D43881

CERTIFICATE OF DEATH.

39 D43881
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1139 N. Milton Ave. ST.; 8 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1139 N. Milton Ave. - St.; 34 yrs., - mos. - ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Male</i>	4-COLOR OR RACE. <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>Widower</i> (Write the word.)
6-DATE OF BIRTH. <i>Dec. 2, 1884</i> (Month) (Day) (Year)		
7-AGE. <i>35</i> yrs. <i>6</i> mos. <i>7</i> ds.		If LESS than 1 day, ...hrs. or....min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). <i>Carpenter</i> <i>Himself</i>		
9-BIRTHPLACE. (State or Country). <i>Germany</i>		
PARENTS.	10-NAME OF FATHER. <i>Unknown</i>	
	11-BIRTHPLACE OF FATHER (State or Country). <i>Germany</i>	
	12-MAIDEN NAME OF MOTHER <i>Unknown</i>	
	13-BIRTHPLACE OF MOTHER (State or Country). <i>Germany</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-JUN 10 1920

ROBERT E. KRAUTER

Filed

191

BUTIKI

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 6* 191*2*, to *June 9* 19*20*.that I saw h*is* alive on *June 8* 19*20*, and that death occurred, on the date stated above, at *1:4* m.

The CAUSE OF DEATH* was as follows:

Exhaustion & T. exaerum.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)*Side of lower jaw (2ndary)*
(Duration).....yrs.....mos.....ds.

(Signed)

M. D.

June 9, 1912 (Address) *477 C. C. Harford Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*Balto. Cem**June 11, 1920*

20-UNDERTAKER

ADDRESS

Philip Herring Orleans St.

important. See instructions on back of certificate.

D43882

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43882

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2514 E. Madison ST.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thelma E. Cooper

(a) RESIDENCE. NO.

2514 E. Madison ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

4 mos. 27 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 12/20

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4 27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

City

10 NAME OF FATHER

Clarence D. Cooper

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Springfield Mass

12 MAIDEN NAME OF MOTHER

Edith M. Roper

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

14

Informant (Address)

Clarence D. Cooper
2514 E. Madison

15

JUN 10 1920ROBERT A. BRADY
Registrar
Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 9 19 20

17

I HEREBY CERTIFY, That I attended deceased from

May 30, 19 20, to June 8, 19 20that I last saw him alive on June 8, 19 20.and that death occurred, on the date stated above, at 12:00 A m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayer M. D., 19 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London ParkJune 10 19 20

20 UNDERTAKER

Philip Herwig

ADDRESS

2016 Orleans

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43883

CERTIFICATE OF DEATH.

80 D43883
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 N Luzerne ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1304 N Luzerne St.; 79 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

November 16, 1840
(Month) (Day) (Year)

7-AGE,

79 yrs., 6 mos., 23 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Plumber

9-BIRTHPLACE, (State or Country),

Cecil Co Md

10-NAME OF FATHER,

John Wilson

11-BIRTHPLACE OF FATHER (State or Country),

Cecil County Md

12-MAIDEN NAME OF MOTHER

Sophia Foster

13-BIRTHPLACE OF MOTHER (State or Country),

Cecil Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. Wilson

(Address) 1304 N. Luzerne Ave

15-

JUN 10 1920 ROBERT B. LAUTER
Filed..... 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 9, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 29 1920, to June 9 1920, that I saw him alive on June 8 1920, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Auriga Pectoris

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

Arterio Sclerosis

(Duration).....yrs.....mos.....ds.

(Signed) B. P. Sterzog M.D.

June 9, 1920 (Address) 1305 N. Patt M. a

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Cathedral Cemetery June 11, 1920

20-UNDERTAKER

ADDRESS

George J. Ruth 1235 Hayford Ave.

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43881

CERTIFICATE OF DEATH.

175-005

D43881

1-PLACE OF DEATH

CITY OF BALTIMORE (No. South Balto. General Hospital, 12

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Woodford. (C)

(Residence in Baltimore: No. 505 Guilford Place.

St.; yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, Colored. 5-SINGLE, MARRIED, WIDOWER, OR DIVORCED, (Write the word.) widower

6-DATE OF BIRTH, Do not know, 1 (Month) (Day) (Year)

7-AGE, 64 yrs. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer in oil works. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Virginia.

10-NAME OF FATHER, Major Woodford. (C)

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER Millie Jefferson. (C)

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert Woodford (C) son.

(Address) 2463 Buchanan St.

15-JUNE 10 1920

ROBERT R. KRAUTER

Filed..... 191

Serial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 8th, 1920, 191 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Brain injuries. Accidental fall from a cart. (Duration) yrs. mos. ds. 6

CONTRIBUTORY (Secondary)

(Signed) Otto M. Rembrandt M. D. (Coroner.)

June 10, 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death. Prudential Oil Works, Fairfield.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER, Chas. G. Bailey

June 10th 1920

D43885

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43885

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Allen(a) RESIDENCE. No. UnknownST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Black</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Unknown</u>
------------------------	---------------------------------	--

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 1865

7 AGE <u>55</u>	Years	Months	Days	If LESS than 1 day, hrs. or min.
--------------------	-------	--------	------	--

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)14 Informant Hospital Records(Address) New City Hospital15 JUN 10 1920 ROBERT E. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 192017 I HEREBY CERTIFY, That I attended deceased from
June 7, 1920, to June 8, 1920.that I last saw her alive on June 8, 1920.and that death occurred, on the date stated above, at 10:00 P.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis AdmitedCONTRIBUTORY Miliary Tuberculosis
(Secondary)18 Where was disease contracted unknown
if not at place of death?Did an operation precede death? no Date of Was there an autopsy? yesWhat test confirmed diagnosis? autopsy findings
(Signed) Frank T. Butler, M. D.June 9, 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park CemeteryJune 10 1920

20 UNDERTAKER

ADDRESS

H. E. Hughes 17 St. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43886

CERTIFICATE OF DEATH.

167

D43886

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Helena Hospital* St. *V*)

WARD)

2-FULL NAME *Esiker Shine*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *9 S Ann*)

St.; yrs., *5* — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)

6-DATE OF BIRTH, 1 (Month) (Day) (Year)

7-AGE *5* yrs. — mos. — ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *none* (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Balt Md*

10-NAME OF FATHER, *Jacob Shine*

11-BIRTHPLACE OF FATHER (State or Country), *Russia*

12-MAIDEN NAME OF MOTHER, *Ida Horowitz*

13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jacob Shine*

(Address) *9 S Ann St*

15- *JUN 10 1920* ROBERT H. KRAUTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 9*, 19*20* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, au- topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: *Burns. Accidents. Play with fire & gas.* (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) *R. H. Krauter* M. D. (Coroner) *69* 1st (Address) *9 S Ann St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL *Hebrew Mt Carmel* DATE OF BURIAL *June 10 1920*

20-UNDERTAKEN *Max Quinson* ADDRESS *E Balt St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43887

CERTIFICATE OF DEATH.

108

D43887

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 N. Bethel ST.; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Delia Stallings

(a) RESIDENCE. No.

402 N. Bethel ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

7 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female Colored married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Alouza Stallings

6 DATE OF BIRTH (month, day, and year)

Unknown 1873

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47 — — —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

general domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

general

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Tallahassee Fla.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Alouza Stallings 402 N. Bethel St.

15

File

JUN 10 1920ROBERT E. KLEIN

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 8, 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 1, 1920 to June 8, 1920.that I last saw her alive on June 7, 1920.and that death occurred, on the date stated above, at 11:00 a.m.

THE CAUSE OF DEATH* was as follows:

Chronic suppurative appendicitis(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Balto. Md.

Did an operation precede death?

no Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical(Signed) Robt. E. KleinM. D.(Address) 1530 Monument St.June 10, 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel cemeteryJune 12, 1920

20 UNDERTAKER

ADDRESS

Mrs. Robt. E. Klein1725Ashland Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. State statement in certificates. See instructions on back of certificates.

D43888

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43888

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balto Eye Ear Throat Hospital*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *2408 Druid Hill Ave*

(Usual place of abode)

WARD.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Jewish White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 16, 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*One**25*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Louise Bates

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Sachinute Russia

12 MAIDEN NAME OF MOTHER

Ida Adler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Sachinute Russia

14

Informant (Address)

Hewie 1411 E. B. St.

15

File

JUN 10 1920

ROBERT E. ELLIOTT Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 10, 1920

17

I HEREBY CERTIFY, That I attended deceased from *May 25, 1920* to *June 10, 1920*, that I last saw her alive on *June 10, 1920*and that death occurred, on the date stated above, at *10.40 a.m.*

The CAUSE OF DEATH* was as follows:

*Streptococcus meningitis*CONTRIBUTORY (Secondary) *Ante mastoiditis* (duration) yrs. mos. ds. *7*

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Yes Date of *June 1, 1920*

Was there an autopsy?

No

What test confirmed diagnosis?

Spinal fluid culture

(Signed)

Joseph I. Klemmer, M.D.

, 19

(Address)

1908 E. B. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Workmen Circle Int'l**6/10 1920*

20 UNDERTAKER

ADDRESS

*Jack Lewis**1411 E. B. St.*

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43889

CERTIFICATE OF DEATH.

137-691 D43889

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

Mannement St.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mrs. Katie Harris

(Residence in Baltimore: No.

Hebrew Hospital 151 N. High St.

St.; 24 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Widow

6-DATE OF BIRTH,

....., 1.....
(Month) (Day) (Year)

7-AGE,

24 yrs. mos. ds.

If LESS than 1 day,hrs. or....min?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

9-BIRTHPLACE, (State or Country),

Unknown

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed

JUN 10 1920

ROBERT A. KRAUTER

Baptist Parsonage

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 8, 1910
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 17, 1910, to June 8, 1910,

that I saw him alive on June 8, 1910,

and that death occurred, on the date stated above, at 3:10 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

6-9-20, 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

UNIVERSITY OF MARYLAND....., 191...

20-UNDERTAKER

ADDRESS 1919

important. See instructions on back of certificate.

Margaret M. Haupt
HEALTH DEPARTMENT—CITY OF BALTIMORE

D43890

CERTIFICATE OF DEATH.

D43890

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *728 S Dallas*)ST.: *3* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Margaret Martha Haupt

(a) RESIDENCE. NO.

728 S Dallas

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Feb. 1920

7 AGE

Years

Months

Days

If LESS than 1 day, ... hrs. or ... min.

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

11

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

James Haupt

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Kelen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poleson

14

Informant (Address)

James Haupt 728 S Dallas

15

P.J.

*JUN 10 1920**ROBERT E. ERASTRE**Robert E. Erastre*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 2 1920*

17

HEREBY CERTIFY, That I attended deceased from

*June 8 1920, to June 9 1920*that I last saw him alive on *June 9 1920*and that death occurred, on the date stated above, at *10 P. M.*

The CAUSE OF DEATH* was as follows:

Scarlet fever & pneumonia & pleurisy(duration) yrs. mos. *1 4* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Sugar & syphilis*(Signed) *W. A. Purcell*, M. D.*June 9 1920 (Address) 1623 8th Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Trinity Cem.**June 11 1920*

20 UNDERTAKER

ADDRESS

James Fialkowski 424 W. Bond

TION is very important. See instructions on back of certificates.

D43891

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43891

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 E. Center ST.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 6 E. Center St.; 4 yrs., 10 mos., 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F

4-COLOR OR RACE,

W.5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH,

Aug131888

(Month)

(Day)

(Year)

7-AGE,

73 yrs., 10 mos., 10 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

George Paine

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Amelia A. Marley

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Robert P. Allen

(Address)

2329 Mondawmin Ave

15-

JUN 10 1920Robert P. Harrison,Registrar.Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June101920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Apr. 24 1920, to June 10 1920,that I saw her alive on June 10 1920,and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

myocarditis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....R. P. Harrison.....M. D.June 10 1920 (Address).....2329 Mondawmin Ave.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Eastern Cemetery

DATE OF BURIAL,

June 11, 1920

20-UNDERTAKER

George J. Smith

ADDRESS

1000 E. Gay St.

important. See instructions on back of certificate.

D43892

Sister Mary Ebba
HEALTH DEPARTMENT—CITY OF BALTIMORE

D43892

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 954. Harbourside

ST.; 16 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 954 Harbourside

St.; yrs., 2 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

W

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

June

(Month)

10

(Day)

1870

(Year)

7-AGE,

49 yrs. 11 mos. 9 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Nephew 065
and so

9-BIRTHPLACE,

(State or Country),

Ireland

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Sister M. Boudenhans

(Address)

954 Harbourside

15-

JUN 10 1920

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June

9

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 8 1920, to June 9 1920,

that I saw him alive on June 9 1920,

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis & Atelectasis
Pneumonia

(Duration) 5 yrs. 11 mos. 9 ds.

CONTRIBUTORY
(Secondary)Pulmonary Embolism
2 yrs.

(Duration) 5 yrs. 11 mos. 9 ds.

(Signed) J. T. O'Brien M. D.

6710, 191... (Address) 804 Calhoun St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

6-9-1920

20-UNDERTAKER

H. B. Manning & Son

ADDRESS 517 N

Schmidt St.

D43893

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43893

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Md. General Hospital* ST. *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Ida Bozman*(a) RESIDENCE. No. *7 W. J. St. Sparrows Point* ST. *3 weeks* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

~~HUSBAND~~ of
(or) WIFE of*James Bozman.*

6 DATE OF BIRTH (month, day, and year)

1879.

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*41*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Md.*

10 NAME OF FATHER

Connelly

11 BIRTHPLACE OF FATHER (city or town)

Md.

(State or country)

12 MAIDEN NAME OF MOTHER

Mary Mangel

13 BIRTHPLACE OF MOTHER (city or town)

Md.

(State or country)

14

Informant
(Address)*James Bozman.*

15

Filed

19

Registrar

Robert P. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 8 1920

17

I HEREBY CERTIFY, That I attended deceased from

*May 31 1920, to June 8 1920,*that I last saw her alive on *June 8 1920,*and that death occurred, on the date stated above, at *11:50 P. m.*

The CAUSE OF DEATH* was as follows:

*Streptococcus septicaemia
Post-cerebral abscess*(duration) yrs. mos. *7* ds.CONTRIBUTORY
(Secondary)(duration) yrs. mos. *1st* ds.18 Where was disease contracted
if not at place of death? *Sparrows Point Md.*Did an operation precede death? *no* Date of *—*Was there an autopsy? *yes*What test confirmed diagnosis? *Blood culture*(Signed) *H. E. Wright* M. D.*48*, 1920 (Address) *Md. General Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mabel Md.

DATE OF BURIAL

June 11 1920

20 UNDERTAKER

Harry H. Witzke

ADDRESS

1531 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificates.

JUN 10 1920

D43891

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43891

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

27 W. Hamilton Ave 27

ST.:

WARD)

2-FULL NAME

Franz Bachmann

(a) RESIDENCE, No.

27 W. Hamilton Ave

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 24 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced (write the word)

Widowed

6a If married, widowed, or divorced

HUSBAND of

Christina Bachmann

6 DATE OF BIRTH (month, day, and year)

Feb 17th 1884

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

86

3

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Linen Weaver

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Germany

10 NAME OF FATHER

John Bachmann

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Germany

14

Informant
(Address)Minnie Christopher
27 W. Hamilton Ave

Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 9th 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 7, 1920, to June 9, 1920,

that I last saw him alive on June 9, 1920,

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Clarence P. M. D.

, 19 (Address)

27 W. Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cemetery

June 14th 1920

20 UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E. Main St.

JUN 10 1920

D43895

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43895

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen. Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Effie P. Painter(a) RESIDENCE. No. 2053 Kennedy Ave. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 13 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22 18967 AGE Years 24 Months 4 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerical

(b) General nature of industry, business, or establishment in which employed (or employer)

Dept Store

(c) Name of employer

Bennett Bros.9 BIRTHPLACE (city or town) Virginia ? (State or country)10 NAME OF FATHER Lemuel Painter11 BIRTHPLACE OF FATHER (city or town) Va (State or country)12 MAIDEN NAME OF MOTHER Elizabeth Mason13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)14 Informant Vernie Painter (Address) 1376 East Capt. St. Wash. D.C.15 Robert P. Harrison Registrar

JUN 10 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-9-2017 I HEREBY CERTIFY, That I attended deceased from 6-5, 1920, to 6-9, 1920.that I last saw her alive on 6-9, 1920.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

1- Acute CholecystitisCONTRIBUTORY (duration) yrs. mos. 6 ds. stenosis of common duct(Secondary) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-7-20Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) R. R. Reynolds, M. D.19 (Address) 1213 - Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Broadway, VirginiaJune 1920

20 UNDERTAKER

ADDRESS

Joseph B. Cook1003 N. Bell St.

D43896

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43896

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 Bradford ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1619 N. Bradford St.; 10 yrs., 10 mos., 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug 23, 1919
(Month) (Day) (Year)

7-AGE, 10 yrs., 10 mos., 10 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country).

Ind.

10-NAME OF FATHER,

Howard Creman

11-BIRTHPLACE OF FATHER (State or Country).

Ind.

12-MAIDEN NAME OF MOTHER

Carrie Fitzgerald

13-BIRTHPLACE OF MOTHER (State or Country).

Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Creman

(Address) 1619 N. Bradford St.

15-

JUN 11 1920

ROBERT A. KRAUTER

Filed

191

Baptist Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 9, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 5 1920, to June 9 1920, that I saw him alive on June 8 1920, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration).....yrs.....mos.....6 ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) James P. Fink M. D.(Address) 1823 N. Harbor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore, Conn.

DATE OF BURIAL,

June 11, 1920

20-UNDERTAKER

Frank A. Fink

ADDRESS

915 N. Gay St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43898

CERTIFICATE OF DEATH.

104 D43898

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

904 Born Alley ST. 18

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Hylah Lee Washington

(Residence in Baltimore: No.

904 Born Alley

St. 1 yrs. 3 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Mar 9, 1919
(Month) (Day) (Year)

7-AGE,

3 yrs. 3 mos. da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Washington

(Address)

904 Born Alley

15-

JUN 11 1920

ROBERT E. TRAUTEN

Burial Place Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 9, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 5, 1920, to June 9, 1920,

that I saw her alive on June 9, 1920,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis
(Duration) ... yrs. ... mos. 7 ds.CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Harry Gleason M. D.

June 10, 1920 (Address) 2687 Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Auburn

June 11, 1920

20-UNDERTAKER

ADDRESS

Brown & Ireland

1407

important. See instructions on back of certificate.

Exact statement of OCCUPA-
TION should be carefully supplied. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec. 6-9-19-H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43899

CERTIFICATE OF DEATH.

79

D43899

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 E. Madison ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua Dixon

(a) RESIDENCE. NO. 1029 E. Madison ST.: 10 WARD.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m. 4 COLOR OR RACE B. 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 81 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) do not know

10 NAME OF FATHER do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) do not know

12 MAIDEN NAME OF MOTHER do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) do not know

14 Informant (Address) Joe Lickson 15-24 Monument St

15 Filed JUN 11 1920 ROBERT E. FRANKLIN Barial Permit, Olay

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/8 1920

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1920, to June 7, 1920, that I last saw him alive on June 7, 1920, and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows:

chronic myocarditis

CONTRIBUTORY (Secondary) hypostatic pneumonia (duration) yrs. mos. ds. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) A. H. Hornstein, M. D.

49, 19 W (Address) 733 Aiguint St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

National Cem June 11, 1920

20 UNDERTAKER ADDRESS 1725

Mrs R A Elliott Seaboard

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D43900

D43900

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1915 Wilhelm* ST.; *20* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1915 Wilhelm* St.; *20* yrs., *20* mos., *20* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write the word.*) *Married*

6-DATE OF BIRTH.

Feb *5*, *1896*
(Month) (Day) (Year)

7-AGE.

24 *4* *3*
yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.
(State or Country),*Charlestown Va*

10-NAME OF FATHER,

*Maurice J. Kane*11-BIRTHPLACE OF FATHER
(State or Country),*Va*

12-MAIDEN NAME OF MOTHER

*Mary O'Connell*13-BIRTHPLACE OF MOTHER
(State or Country),*Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Albert Streich*(Address) *1915 Wilhelm St*

15-

Filed *JUN 11 1920*

ROBERT E. LAUTNER

BOSCHER & SONS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 8, *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 5 *1920*, to *June 8* *1920*that I saw her alive on *June 8* *1920*and that death occurred, on the date stated above, at *11:59* am.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(Duration) *3* yrs. *3* mos. *3* ds.CONTRIBUTORY
(Secondary)(Duration) *1* yrs. *1* mos. *1* ds.(Signed) *M. J. O'Connell* M. D.*June 9*, *1920* (Address) *108 N. Fulton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *24* yrs. *4* mos. *3* ds. In the State *20* yrs. *20* mos. *20* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Louisa Park Cem *June 10*, *1920*

20-UNDERTAKER.

M. J. Flynn

ADDRESS

1422 Light

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43901

CERTIFICATE OF DEATH.

REGISTERED NO.

D43901

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 N. Linwood Ave. ST. 6 WARD)

2-FULL NAME

Theresa E. Proctor

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 111 N. Linwood Ave. ST. 6 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) married5a If married, widowed, or divorced HUSBAND of D. M. Proctor (or) WIFE of6 DATE OF BIRTH (month, day, and year) Aug. 5-18827 AGE Years 37 Months 10 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) md.10 NAME OF FATHER Sigmund Dengler11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) md.12 MAIDEN NAME OF MOTHER Catharine Hugel13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) md.14 Informant Catharine Dengler (Address) 111 N. Linwood Ave.15 Filed JUN 11 1920 ROBERT E. KRATZER

Burial Permit 0122

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 192017 I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1920 to June 9, 1920, that I last saw him alive on June 9, 1920, and that death occurred, on the date stated above, at 12.30 A. M. The CAUSE OF DEATH* was as follows:Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of about 6 weeks ago - Dr. W. F. H. at Church HomeWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Theodore H. Morrison M. D.19 (Address) 1013 N. E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Am.June 12 1920

20 UNDERTAKER

ADDRESS

Lilly Geo Zeller4038 Maple St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43902

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

IF LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

ROBERT E. KRAUTER

FULL JUN 11 1920 191... Burial Permit... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.

And that said deceased came to death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH was as follows:

Fracture skull, arm, ribs auto accident

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James W. Kenton M. D. (Coroner.)

June 10, 1920 (Address) 200 E. Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 638 Pitcher St.

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL

Cathedral Cemetery June 12, 1920

20-UNDERTAKER

ADDRESS

James W. Kenton 1364 Maryland

D43903 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 18/1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Ralph W. Clarke

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Utah

12 MAIDEN NAME OF MOTHER

Christina Sommer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Maryland

14

Informant (Address)

Ralph W. Clarke 825 S. Second St

15

Filed

JUN 11 1920

ROBERT E. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 10 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 6, 1920, to June 10, 1920,

that I last saw her alive on June 10, 1920,

and that death occurred, on the date stated above, at 6:20 P. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) J. B. Titlow M. D.

19 Address 2921 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Trinity Cemetery June 11 1920

20 UNDERTAKER

ADDRESS

J. Sander Sou 1710 West St

D43901 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *719 Dolphin St*)ST.: *17* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Rosine P. Thure*(a) RESIDENCE. NO. *719 Dolphin*
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *69* yrs. mos. ds. How long in U. S., if of foreign birth? *69* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

*White*5 Single, Married, Widowed,
or Divorced (write the word)*Widow*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Jacob Thure*6 DATE OF BIRTH (month, day, and year) *July 22, 1835*

7 AGE

Years

Months

Days

If LESS than
1 day,.....hrs.
or.....min.*85**3**17*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*None*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *near Stuttgart*
(State or country) *Germany*

10 NAME OF FATHER

Jacob Fischer

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Germany*12 MAIDEN NAME OF MOTHER *Rachel Sauer*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

(Address)

*Carl E. Ficht (grandson)**719 Dolphin*

15

Filed

*JUN 11 1920*ROBERT I. KLAUTER
Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 9* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

July, 19*12*, to *June 9*, 19*20*,that I last saw *her* alive on *June 8*, 19*20*,and that death occurred, on the date stated above, at *5:30 a.m.*

The CAUSE OF DEATH* was as follows:

old age

(duration)yrs.mos.ds.

CONTRIBUTORY
(Secondary)

(duration)yrs.mos.ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Geo. T. Kemp*, M. D.June 9, 1920 (Address) *St James apartments*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Fredson Park Cemetery**June 11 1920*

20 UNDERTAKER

ADDRESS

*W. M. Routson**2238 W North*

CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43905

CERTIFICATE OF DEATH.

79

D43905

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 124 W. Lafayette St. 14

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry M. Levy

(Residence in Baltimore: No. 124 W. Lafayette St. 3

yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, widower (Write the word.)

6-DATE OF BIRTH, October 1, 1935 (Month) (Day) (Year)

7-AGE, 84 yrs. 8 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, retired (b) General nature of industry, business, or establishment in which employed (or employer), cigar merchant

9-BIRTHPLACE, (State or Country), Austria

10-NAME OF FATHER, Colan Salem Keller

11-BIRTHPLACE OF FATHER, (State or Country), Austria

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Signatures Levy

(Address), 124 W. Lafayette St.

15-

Filing JUN 11 1920

ROBERT E. KRAUTER

Burial Permit Office

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 9, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by inquiry (Inquest, au-

quity and that said deceased came death (Inquest, au- topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration), yrs. 6 mos. ds.

CONTRIBUTORY (Secondary), Chronic Prostatitis

(Duration), 1 yrs. mos. ds.

(Signed), J. A. Hennessy M. D.

(Coroner), June 10, 1920, (Address), 2802 Edmondman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

London Park June 12, 1920

20-UNDERTAKER, ADDRESS, Wm Cook 5025 North

1 Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43906

Chrusniak
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

174 D43906

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

Calverly Bldg 1
Harry C. Chrusniak
2612 Fleet St.

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 27 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OF RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)

6-DATE OF BIRTH, *January 27, 1882*
(Month) (Day) (Year)

7-AGE, *38* yrs. *4* mos. *13* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Butcher*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Poland*

10-NAME OF FATHER, *John Armonist*

11-BIRTHPLACE OF FATHER (State or Country), *Poland*

12-MAIDEN NAME OF MOTHER, *Katharina Makowicka*

13-BIRTHPLACE OF MOTHER (State or Country), *Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joe Chrusniak*

(Address) *2612 Fleet St.*

15- *JUN 11 1920* *ROBERT E. LAUTER*

2612 Fleet St. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 8, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) And that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Prob. fract. spine, caused by accident, fall down Elevator shaft

CONTRIBUTORY (Secondary) *Slipping*

(Signed) *W. H. White* M. D.

Jan 10, 1920 (Address) *1639 Bay*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *Jan 1920* of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Stanislaus* DATE OF BURIAL, *Jan 20, 1920*

20-UNDERTAKER, *M. F. Sadowski* ADDRESS, *405 S. Ann St.*

D43907

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 Light St.

ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mildred Beauchamp

(a) RESIDENCE. NO.

720 Light St.

ST.: 22 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1 1918

7 AGE Years 1 Months 11 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

10 NAME OF FATHER Alvin S. Beauchamp

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md. (State or country)

12 MAIDEN NAME OF MOTHER Myrtle Hill

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md. (State or country)

14 Informant Alvin S. Beauchamp (Address) 720 Light St.

15 JUN 11 1920 ROBERT E. KRAUTER Registrar Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUN 10 1920

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1920, to June 10th, 1920, that I last saw her alive on June 10th, 1920, and that death occurred, on the date stated above, at 10-2 a. m. The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 4 ds. CONTRIBUTORY (Secondary) Whooping Cough (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. Buxton, M. D.

6/11/1920 (Address) 301 E. Green St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

CEDAR HILL

JUN 11 1920

20 UNDERTAKER

JOHN F. DENNY 715 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

D43908

HEALTH DEPARTMENT—CITY OF BALTIMORE✓

CERTIFICATE OF DEATH.

152 D43908

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 Edmondson Ave. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ruby Davis

(a) RESIDENCE. NO.

1317 Edmondson Ave.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Infant5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 6, 1920

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore, Md.

10 NAME OF FATHER

Henry J. Davis11 BIRTHPLACE OF FATHER (city or town)
(State or country)Fredrick Co. Md.

12 MAIDEN NAME OF MOTHER

Mary E. Wolfe13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Howard Co. Md.

14

Informant
(Address)Henry J. Davis
1317 Edmondson Ave.

15

JUN 11 1920ROBERT E. BLAUSTEINRegistrar
Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 10 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 6, 1920, to June 10, 1920,that I last saw him alive on June 9, 1920,and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Congenital Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Asphyxia Neonatorum

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. H. Machin, M. D.19 (Address) 4119 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Machin Co.June 11 1920

20 UNDERTAKER

ADDRESS

Amiel TaylorPa. Ave.

CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 781 W. Saratoga ST.; 4 WARD)

2-FULL NAME

(Residence in Baltimore: No. 781 W. Saratoga

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 5 yrs., X mos., X ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)Married

6-DATE OF BIRTH,

1861
(Month) (Day) (Year)

7-AGE,

59 yrs., - mos., - ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Housewife9-BIRTHPLACE,
(State or Country)Md.

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

File

JUN 11 1920ROBERT E. KRAUTHBurial Permit - 0407

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 9, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Feb 19, 1920 to June 9, 1920,
that I saw her alive on June 8, 1920,and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Brights(Duration) 3 yrs., 9 mos., 9 ds.CONTRIBUTORY
(Secondary)(Duration) 0 yrs., 0 mos., 0 ds.(Signed) R. B. Thompson M. D.June 9, 1920 (Address) 609 W. Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

St. Johns June 11, 1920

20-UNDERTAKER

Amel Easton ADDRESS 916

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43910 HEALTH DEPARTMENT—CITY OF BALTIMORE
174 D43910
CERTIFICATE OF DEATH.
1-PLACE OF DEATH *Lombard St Bridge*
CITY OF BALTIMORE (No. *13* ST. *13* WARD)
2-FULL NAME *Thomas A. Ball*
(Residence in Baltimore: No. *3609 Cedar Ave* St.; yrs. *4* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.
3-SEX *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widowed*
6-DATE OF BIRTH, 1
(Month) (Day) (Year)
7-AGE, *32* yrs. mos. ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Brickman*
(b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country), *Maryland*
10-NAME OF FATHER, *John Ball*
11-BIRTHPLACE OF FATHER (State or Country), *MD*
12-MAIDEN NAME OF MOTHER *Ellen M. Ball*
13-BIRTHPLACE OF MOTHER (State or Country), *MD*
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Ellen M. Ball*
(Address) *3609 Cedar Ave*

15- Filled JUN 11 1920 ROBERT E. KRAUTH
Bureau of Health

CORONER'S CERTIFICATE OF DEATH.
16-DATE OF DEATH, *June 10, 1920*
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, au-
topsy or inquiry.)
The CAUSE OF DEATH* was as follows:
Accidentally killed while traveling on a train under the hood of a locomotive
(Duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary) (Duration) yrs. mos. ds.
(Signed) *Obeney S. Rader* M. D. (Coroner)
6/10, 1920 (Address) *1610 E. Baltimore St.*
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence
19-PLACE OF BURIAL OR REMOVAL, *St. Marys Cemetery* DATE OF BURIAL, *June 12, 1920*
20-UNDERTAKER, *Chenoweth & Son* ADDRESS *Chestnut St.*

D43911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43911

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1827 Riggs Ave* ST.; *16* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1827 Riggs Ave* St.; *13* yrs., *about* mos., *1* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

June 8, 1845
(Month) (Day) (Year)

7-AGE,

75 yrs., *2* mos., *2* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired Nurse

9-BIRTHPLACE, (State or Country),

Mt Holly Ohio.

10-NAME OF FATHER,

Joseph Powell.

11-BIRTHPLACE OF FATHER (State or Country),

New Jersey.

12-MAIDEN NAME OF MOTHER

Sarah Dorn.

13-BIRTHPLACE OF MOTHER (State or Country),

New Jersey.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Catherine E. Abell*(Address) *1337 N. Calver St.*

15-

JUN 11 1920

ROBERT E. KAUTER

Burial in City of Baltimore

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 11, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 11, 1920, to June 11, 1920.*that I saw her alive on *June 11, 1920.*

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: *(see note on back)*

.....

.....

.....

.....

..... (Duration) yrs. mos. *2 hrs.*

CONTRIBUTORY (Secondary)

Arterio sclerosis and Mitral Regurgitation

..... (Duration) yrs. mos. ds.

(Signed) *Geo. C. Shannon* M. D.*June 11th, 1920* (Address) *700 Fulton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

June 14, 1920

20-UNDERTAKER

William J. G. E.

ADDRESS

1225 W. Lafayette

important. See instructions on back of certificate.

D43912

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43912

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: WARD)

2-FULL NAME

(a) RESIDENCE. No.

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

JUN 11 1920

Robert P. PRISON,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1920

17 I HEREBY CERTIFY, That I attended deceased from
June 10, 1920 to June 11, 1920.

that I last saw him alive on June 11, 1920

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation
(Signed) J. B. Linton, M. D.

6/11/20 (Address) 2921 Odumwell St

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary Cem June 12 1920

20 UNDERTAKER

ADDRESS

Stephen J. Fialkowski 1000 K...

D43913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43913

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *5423 Oak Heights Ave* ST. *27* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John Tramor*(Residence in Baltimore: No. *about 50 yrs* St. *27* yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE, *W*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)6-DATE OF BIRTH, *Sept 12, 1855*

(Month)

(Day)

(Year)

7-AGE, *65 yrs 8 mos 28 ds*

yrs. mos. ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Plumber*
(b) General nature of industry, business, or establishment in which employed (or employer) *Employed*9-BIRTHPLACE, (State or Country), *Ireland*10-NAME OF FATHER, *Frank Tramor*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER *Elizabeth Duffy*13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert P. Harrison*(Address) *5423 Oak Heights Ave*

15-

JUN 1 1920

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 9th, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Feb 2, 1920* to *June 10, 1920*

1920

1920

that I saw him alive on *June 10, 1920*and that death occurred, on the date stated above, at *11 P* m.

The CAUSE OF DEATH* was as follows:

*Apoplexy**10 minutes*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Flu Rheumatism*

(Duration) yrs. mos. ds.

(Signed) *W. H. Mears* M. D.6/11/20, 191... (Address) *Washington*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery

DATE OF BURIAL,

6/12, 1920.

20-UNDERTAKER

Henry W. Mears & Son

ADDRESS

805 N. Calvert St.

D4391E

HEALTH DEPARTMENT—CITY OF BALTIMORE

D4391E

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 13 WARD)2-FULL NAME Slater A. Yursik (YURSIK)(a) RESIDENCE. No. 2312 Eutaw Place ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 8 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widower5a If married, widowed, or divorced Barbara Warriner
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18777 AGE 42 Years 8 Months 3 Days If LE than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale(b) General nature of industry, business, or establishment in which employed (or employer) Provision

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)10 NAME OF FATHER Anton Yursik11 BIRTHPLACE OF FATHER (city or town) Austria
(State or country)12 MAIDEN NAME OF MOTHER Zilanke13 BIRTHPLACE OF MOTHER (city or town) Austria
(State or country)14 Informant University Data
(Address) Green Lombard15 Robert P. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-11 19 2017 I HEREBY CERTIFY, That I attended deceased from
6/5 1920 to 6/11 1920
that I last saw him alive on 6/11 1920
and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiencyCONTRIBUTORY (Secondary) Acute gangrenous
appendicitis (duration) yrs. mos. 7 ds.18 Where was disease contracted 2312 Eutaw Place
if not at place of death? 6/5/20Did an operation precede death? yes Date of 6/5/20Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. A. Ryschman, M. D.
6/11 1920 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park Cemetery6/14 19 20

20 UNDERTAKER

ADDRESS

Henry W. Mears & Son 805 N. Calver St.

JUN 11 1920

D43915

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43915

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 N. Arlington Ave ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Rosa Rand

(a) RESIDENCE. No. 919 N. Arlington Ave. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 18 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 29, 1920

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
71 2 12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Actress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Virginia

10 NAME OF FATHER Oliver Rand

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia14 Informant Mrs. John W. Bailey
(Address) 919 N. Arlington Ave.

15 Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1918, to June 10, 1920, that I last saw her alive on June 10, 1920, and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Spoplexy

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis and Chronic Interstitial Nephritis.

18 Where was disease contracted if not at place of death? In Maryland was.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? The physical signs

(Signed) Charles G. B. M. D.

June 11, 1920 Address) 1111 W. Lammock St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park Cemetery

June 12 1920

20 UNDERTAKER

ADDRESS

Joseph B. Cook 1003 N. Ball's Street

JUN 11 1920

D43916

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43916

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 309 Annapolis Ave. 25 WARD)

2-FULL NAME

Caroline E. Fried

(Residence in Baltimore: No. 309 Annapolis

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 67 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Aug 28, 1860 (Month) (Day) (Year)

7-AGE, 59 yrs. 9 mos. 17 ds. If LESS than 1 day,hrs. ormin.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Homemaker (b) General nature of industry, business, or establishment in which employed (or employer). at home

9-BIRTHPLACE, (State or Country), Balto city

10-NAME OF FATHER, Gottlieb Patter

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Catherine Estruchen

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Cooper

(Address) 309 Annapolis Ave.

15- Robert P. Harrison,

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 9, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(Duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Harrison M. D. (Coroner.)

June 10, 1920 (Address) 200 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, June 12, 1920

20-UNDERTAKER, Mrs. J. W. Tenzel

ADDRESS, 801 N. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

JUN 11 1920

Burial Permit

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43917

D43917

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 N. Eden St ST. 10 WARD)

2-FULL NAME

Angeline Dorey

(a) RESIDENCE. No.

717 N. Eden St

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE Colo 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1868

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

52

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

St Marys Co Md

10 NAME OF FATHER

Richard Dorey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

md

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

md

14

Informant (Address)

Silvery Johnson
717 N. Eden St

15

Filed . 19

Robert F. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 19 20

17

I HEREBY CERTIFY, That I attended deceased from May 24 - 19 20 to June 10 19 20, that I last saw her alive on June 10 19 20, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Bright Disease & Epilepsy(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

Bright Disease & Epilepsy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) H. G. W. Kennard M. D.
610 1920 (Address) 708 Euseb St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Marhanceville Md June 18 19 20
20 UNDERTAKERMrs Robt A Elliott Ashland

JUN 11 1920

D43918

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43918

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2452 Eutaw Place ST.: 13 WARD)

2-FULL NAME

Harriet B. Blackshere

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

2452 Eutaw Place ST.,

WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 45 yrs.

mos.

ds. How long in U. S., if of foreign birth? 45 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white widow

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofElias A. Blackshere

6 DATE OF BIRTH (month, day, and year)

1844

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.76

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Penn

10 NAME OF FATHER

Wm Gray

11 BIRTHPLACE OF FATHER (city or town)

Pa

(State or country)

12 MAIDEN NAME OF MOTHER

Catharine Robinson

13 BIRTHPLACE OF MOTHER (city or town)

Pa

(State or country)

14

Informant
(Address)Albert E. Donaldson
2452 Eutaw Place

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 9 1920

17

I HEREBY CERTIFY, That I attended deceased from

June, 1919, to June 9, 1920.that I last saw him alive on June 9, 1920.and that death occurred, on the date stated above, at 11 40 m.

The CAUSE OF DEATH* was as follows:

Atherosclerosis(duration) 2 yrs. 2 mos. 2 ds.CONTRIBUTORY
(Secondary)(duration) 2 yrs. 2 mos. 2 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of ✓Was there an autopsy? NoWhat test confirmed diagnosis? clinical(Signed) J. Frederick Lutz, M. D.4/17, 1920 (Address) 2452 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Druid Ridge June 12 1920

20 UNDERTAKER

ADDRESS

John Mitchell 2011 W. Fayette

UN17 1920

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43919

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *Windsor Mill Road & Guyman St. 28* WARD)

2-FULL NAME *Mrs Charlotte Sweitzer*

(Residence in Baltimore: No. *Windsor Mill Road & Guyman St. 50* yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Widow* (If write the word)

6-DATE OF BIRTH *Dec 18*, 1840 (Month) (Day) (Year)

7-AGE *79* yrs. *5* mos. *23* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work *retired*
(b) General nature of industry, business, or establishment in which employed (or employer) *ood*

9-BIRTHPLACE (State or country) *Pa*

10-NAME OF FATHER

Samuel Pettigrew

11-BIRTHPLACE OF FATHER (State or country) *Pa*

12-MAIDEN NAME OF MOTHER *Charlotte Clayland*

13-BIRTHPLACE OF MOTHER (State or country) *MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Frances B. Seth*

(Address) *Windsor Mill Road*

15

Robert P. Harrison,

191 Burial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *June 10*, 19*20* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 13*, 19*20*, to *June 10*, 19*20*, that I saw her alive on *June 10*, 19*20*, and that death occurred, on the date stated above, at *P* m. The CAUSE OF DEATH* was as follows:

Uraemia
(*Uraemic Coma*)

(Duration) *0* yrs. *0* mos. *2* ds.
Contributory *Chronic Nephritis. Arterio-*
(SECONDARY) *Sclerosis* or more (Duration) *10* yrs. mos. ds.
(Signed), *S. A. Dadds* M. D.
June 11, 1920 (Address) *3101 Clifton Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Louisa Park *June 12, 1920*

20-UNDERTAKER

John Ouitdell 1201 N. Fayette

JUN 11 1920

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

143920

HEALTH DEPARTMENT—CITY OF BALTIMORE

143920

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. Hanover & Church Sts.

ST. 23

WARD)

REGISTERED No. C.

2-FULL NAME Joseph H. Strider Jr.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1913 Hanover St.

St.; yrs. 10. mos. 4 ds. 23

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single. (Write the word.)

6-DATE OF BIRTH, January 17th. 1910. (Month) (Day) (Year)

7-AGE, 10 yrs. 4 mos. 23 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Baltimore Md.

10-NAME OF FATHER, Joseph H. Strider Sr.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Ellen C. Stewart.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph H. Strider Sr. (father)

(Address) 1913 Hanover St.

15- Robert P. Harrison, ID1

JUN 11 1920

Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 9th. 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage. Accidentally run over by auto truck license #8-228 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. (Signed) Otto M. Remhardt M. D. (Coroner) June 11, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Ceme

DATE OF BURIAL, June 12, 1920

20-UNDERTAKER, W. J. Flynn

ADDRESS, 1422 E. 9th St.

Calvert 1733-W.
Spec. 6-9-19 H. P. Co. 1000 Bks.

D43921

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43921

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

310 Pine

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thomas Franklin Coardley

(a) RESIDENCE. NO.

310 Pine

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

21 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 4, 1909

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

21

2

—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Hostler

(b) General nature of industry, business, or establishment in which employed (or employer)

024

(c) Name of employer

Moses Fox

9 BIRTHPLACE (city or town) (State or country)

Balto

Ind

10 NAME OF FATHER

John Coardley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

Ind

12 MAIDEN NAME OF MOTHER

Florence Haynes

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Tappahan

Va

14

Informant (Address)

Mrs Florence Coardley
310 N. Pine St

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 9 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 3, 1920, to June 9, 1920

that I last saw him alive on June 9, 1920.

and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Pulmonary Edema

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wilbert F. Fowler, M. D.

(Address) 767 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Ambrose Church

June 12 1920

20 UNDERTAKER

Samuel J. Hunsley

ADDRESS

578 N. E. St.

UN12-1920

D43922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY, That I attended deceased from

June 4 1920, to June 9 1920,

that I saw her alive on June 8 1920,

and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

(Duration) 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 7 mos. ds.

(Signed) J. P. Hughes, M. D.

June 9, 1920. (Address) 724 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

JUN 12 1920

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

D43923

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43923

CERTIFICATE OF DEATH.

136

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 Plum Alley ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lizzie Young

(a) RESIDENCE. NO.

1008 Plum

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs.

mos.

ds. How long in U. S., if of foreign birth Life yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofRobert B. Young

6 DATE OF BIRTH (month, day, and year)

June 1891

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Alfred Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Va

12 MAIDEN NAME OF MOTHER

Beelia Gaines

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va

14

Informant
(Address)Robert B. Young
100 Plum Alley

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 10, 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 9, 1920, to June 10, 1920,that I last saw her alive on June 10, 1920,and that death occurred, on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. C. Deliz. M. D.June 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hilmarock Whf.June 1920

20 UNDERTAKER

Sancastr Co. Va.ADDRESS 142John H. ToadwinW. Hill St

JUN 12 1920

CASE OF DEATH IN plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43924

28 D43924

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Steve Theodoris(a) RESIDENCE. NO. 108 S. Paca St.ST. 4 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town)
(State or country) Greece10 NAME OF FATHER Louis Theodoris11 BIRTHPLACE OF FATHER (city or town)
(State or country) Greece12 MAIDEN NAME OF MOTHER Angelica Pom13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Greece14 Informant Hospital Records
(Address) U. T. H.15 Filled Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1920

17 I HEREBY CERTIFY, That I attended deceased from
June 1, 1920, to June 10, 1920.
that I last saw him alive on June 10, 1920.
and that death occurred, on the date stated above, at 2.35 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
(duration) 1 yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? No Date of 4Was there an autopsy? NoWhat test confirmed diagnosis? T.B. in sputum.(Signed) George H. Williams, M. D.
6-10-20, 1920 Address Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cem6-12-20 1920

20 UNDERTAKER

ADDRESS 178Robert Brooks & SonCalhoun St

JUN 12 1920

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43925

CERTIFICATE OF DEATH.

18 ✓ D43925

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Ignace Hospital* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

70

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Laborer

6 DATE OF BIRTH (month, day, and year)

1833

7 AGE

Years

Months

Days

87

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Peter Lynn

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Kannah Hester

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Mrs. John Lynn
2620 Camden Ave

15

Filed

Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 11 1920

17

I HEREBY CERTIFY, That I attended deceased from

1920, to June 11, 1920

that I last saw him alive on

June 11, 1920

and that death occurred, on the date stated above, at 4:40 P. M.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

At place of death

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Observation

(Signed) Frank V. Laegre, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral

June 14 1920

20 UNDERTAKER

ADDRESS

Martin Fahey - 1821 W. North Ave

D43926

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43926

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *645 N. Fulton Ave* ST. *16* WARD)

2-FULL NAME

(Residence in Baltimore: No. *645 N. Fulton Ave* St. *5* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)*Married*

6-DATE OF BIRTH,

May 18, 1869
(Month) (Day) (Year)

7-AGE,

37 yrs. *24* mos. ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*066 Salesman*9-BIRTHPLACE,
(State or Country),*Richmond Va*

10-NAME OF FATHER,

*Herman Ross*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Agnes Ettinger*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mo Ross*(Address) *Edmond St*

15-

JUN 12 1920

Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 11, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *April 21, 1920*, to *June 11, 1920*, that I saw him alive on *June 9, 1920*, and that death occurred, on the date stated above, at *10:4* m. The CAUSE OF DEATH* was as follows:*Sarcoma (of ilium)*
(clinical diagnosis)
(Duration) *8* yrs. *8* mos. *8* ds.
CONTRIBUTORY *Bronchopneumonia*
(Secondary)
(Duration) *5* yrs. *5* mos. *5* ds.
(Signed) *John P. Haulings, M. D.*
June 11, 1920 (Address) *1207 E. Pratt St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *5* yrs. *5* mos. *5* ds. In the State *5* yrs. *5* mos. *5* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Christ Shalom

DATE OF BURIAL,

June 13, 1920

20-UNDERTAKER

Amos Soudherin

ADDRESS

115 W. Kopyak

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43927

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43927

CERTIFICATE OF DEATH.

PLACE OF DEATH In a boat at the foot of

REGISTERED No. C

CITY OF BALTIMORE (No. Hanover Street. St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Christy.

(Residence in Baltimore: No. 2303 E. Federal Street. St. yrs. 46 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married. (Write the word.)

6-DATE OF BIRTH, August 19th, 1859. (Month) (Day) (Year)

7-AGE, 60 yrs. 8 mos. 22 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Stereotypist. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Pennsylvania.

10-NAME OF FATHER, William Christy. 11-BIRTHPLACE OF FATHER (State or Country), Scotland. 12-MAIDEN NAME OF MOTHER, Martha Dalzell. 13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Raymond Christy. (son). (Address) 2303 E Federal Street.

15- Robert P. Harrison, Registrar. 191. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 10th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry. And that said deceased came to his death on the day stated above. The CAUSE OF DEATH was as follows:

Valvular Disease of the Heart. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) Otto M. Reinhardt M. D. (Coroner.) June 11th, 20 (Address) 1017 St. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery. DATE OF BURIAL, June 12, 1920.

20-UNDERTAKER, Robt J Turner. ADDRESS, 412 Broadway.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43928

D43928

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1510 Bayle* ST. *24* WARD)2-FULL NAME *Mary a Williamson*(a) RESIDENCE. NO. *1510 Bayle* ST. *24* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. *5*mos. *8*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed,
or Divorced (write the word) *Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *June 3 1920*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work *None*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) *Balto. Md.*10 NAME OF FATHER *Harwood Williamson*11 BIRTHPLACE OF FATHER (city or town)
(State or country) *Balto. Md.*12 MAIDEN NAME OF MOTHER *Catherine Anderson*13 BIRTHPLACE OF MOTHER (city or town)
(State or country) *Balto.*

14

Informant
(Address) *Harwood Williamson
1510 Bayle St.*

15

Filed

JUN 12 1920

19

Robert P. Harrison

Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)ST. *24* WARDST. *24* WARD.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 11 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*June 4, 1920, to June 11, 1920*that I last saw him alive on *June 11, 1920*and that death occurred, on the date stated above, at *10 P m.*

The CAUSE OF DEATH* was as follows:

acute Gastro-Enteritis(duration) yrs. mos. *7* ds.CONTRIBUTORY
(Secondary)(duration) yrs. mos. *1* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *R. H. Campbell* M. D.June 12, 1920 (Address) *1644 Lenoir St.**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cedar Hill Cemetery**June 14 1920*

20 UNDERTAKER

ADDRESS

*Robt J Turner**1442 1/2 Broadway*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D43929

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43929

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Ma. General Hospital*)ST.: *13* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elizabeth M. Kraus

(a) RESIDENCE. NO.

736 W. North Ave

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

(or) WIFE of

late Fredk Wm Kraus

6 DATE OF BIRTH (month, day, and year)

Dec. 4th 1854

7 AGE

65

Years

6

Months

7

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto., Md

10 NAME OF FATHER

Jno. G. Kestler

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mrs E. T. Miller 736 W. North Ave Balto

15

*JUN 12 1920**Robert P. Harrison*
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 11 1920

17

I HEREBY CERTIFY, That I attended deceased from

*May 28 1920 to June 11 1920*that I last saw him alive on *June 11 1920*and that death occurred, on the date stated above, at *430 P.* m.

The CAUSE OF DEATH* was as follows:

Diabetic mellitus

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

*736 W. North Ave.*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

Blood + urinalysis

(Signed)

Ed S. Wright M. D.

11 1920 (Address)

Ma General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**June 14/20*

20 UNDERTAKER

Wilbur W. Shriver

ADDRESS

1018 E. Dimond

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D43930

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43930

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *2816 Woodbrook Ave* ST.; *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John Harry Hansen*(Residence in Baltimore: No. *2816 Woodbrook Ave* St.; *3* yrs., *3* mos., *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *M*4-COLOR OR RACE *W*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH, *Oct 2, 1914*

(Month)

(Day)

(Year)

7-AGE, *5 7 10*

yrs. mos. ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *OOV*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country) *New York*10-NAME OF FATHER, *John Harry Hansen*11-BIRTHPLACE OF FATHER (State or Country), *Norway*12-MAIDEN NAME OF MOTHER, *Alice Hansen*13-BIRTHPLACE OF MOTHER (State or Country), *Norway*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Harry Hansen*(Address) *2816 Woodbrook Ave*

15-

Robert P. Harrison, Jr.

191

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 12, 1920*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I attended deceased from *June 6, 1920*, to *June 12, 1920*that I saw him alive on *June 12, 1920*and that death occurred, on the date stated above, at *1230* a.m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) *C. S. Lloyd* M. D.*June 12, 1920* (Address) *2232 Euston St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Western Cam*DATE OF BURIAL, *June 12, 1920*20-UNDERTAKER, *Isaiah Sykes*ADDRESS, *1600 N. York Ave*

JUN 2 1920

D43931

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43931

83

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital.ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Williams(a) RESIDENCE. No. 1808 Maryland AveST.: 17 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. Life mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

Female

Black

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

50

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Housework

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.10 NAME OF FATHER Abraham Good11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14

Informant Hospital Records(Address) New City Hospital.

15

Piled Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 28, 19 20 to June 10, 1920.that I last saw her alive on June 10, 19 20.and that death occurred, on the date stated above, at 7:00 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Infected Venereal
ulcers of legs.
(duration) Unknown yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? No Date of —Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank T. Bartlett M. D.19 PLACE OF BURIAL, CREMATION OR REMOVAL New City Hospital*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

At Auburn June 13 1920

20 UNDERTAKER

Wm. Cook

ADDRESS

602 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 12 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43932

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2010 Kennedy in ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura E. Thompson(a) RESIDENCE. No. 2010 Kennedy in ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofWm J. Thompson6 DATE OF BIRTH (month, day, and year) May 2/18477 AGE Years 73 Months 1 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore10 NAME OF FATHER Geo W. Hayes11 BIRTHPLACE OF FATHER (city or town)
(State or country)Md12 MAIDEN NAME OF MOTHER Sarah Enders13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Md14 Informant J. W. Thompson
(Address) 2010 Kennedy in15 Filed Robert P. Harrison

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1920

17

I HEREBY CERTIFY, That I attended deceased from June 8, 1920, to June 11, 1920, that I last saw her alive on June 10, 1920, and that death occurred, on the date stated above, at 9.45 a. m. The CAUSE OF DEATH* was as follows:Cerebral Hemorrhage(duration) yrs. mos. 3 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? hem(Signed) Hubert C. Knapp, M. D.6-11-1920 (Address) 1716 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount6-12 1920

20 UNDERTAKER

ADDRESS

Wm CorkAt GML

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXAMINER OF OCCUPATION is very important. See instructions on back of certificates.

D43933

HEALTH DEPARTMENT-CITY OF BALTIMORE

D43933

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

Calvert Road + Franklin St. 20

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Lillian Marshall

(Residence in Baltimore: No.

House of the Good God Shepherd
Calvert Road + Franklin St.

St.: 15 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

May

22, 1893

(Month)

(Day)

(Year)

7 AGE

27

yrs.

mos.

ds.

If LESS than
1 day, hrs.
or min.?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

Sewing

069

9 BIRTHPLACE
(State or country)

New York

PARENTS

10 NAME OF
FATHER

Unknown

11 BIRTHPLACE
OF FATHER
(State or country)

New York

12 MAIDEN NAME
OF MOTHER

Unknown

13 BIRTHPLACE
OF MOTHER
(State or country)

New York

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sister of the Good Shepherd

(Address)

Calvert Road + Franklin St.

15

Robert P. Harrison,

191

Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June

11

1912

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

March 1st

1912, to,

June 11

1912.

that I saw him alive on June 9, 1912.

and that death occurred, on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows:

Fibular disease of
heart

(Duration) yrs. 3 mos. ds.

Contributory
(SECONDARY)

genuine dropsy

(Duration) yrs. mos. 21 ds.

(Signed) J. R. Byrne M. D.

June 11, 1912 (Address) 570 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

St. Peter's

DATE OF BURIAL

June 12, 1912

20 UNDERTAKER

George Lehman + 4130

ADDRESS

2101 Park Ave

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 12 1920

D43934

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43934

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital.ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen Whartan(a) RESIDENCE. No. Unknown

(Usual place of abode)

ST. Unknown WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1845

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

75

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

West Virginia

10 NAME OF FATHER

James Whartan

11 BIRTHPLACE OF FATHER (city or town)

Virginia

(State or country)

12 MAIDEN NAME OF MOTHER

Elizabeth Harvey

13 BIRTHPLACE OF MOTHER (city or town)

Virginia

(State or country)

14

Informant

Hospital Records.

(Address)

New City Hospital.

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 9, 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 2, 1920, to June 9, 1920,

that I last saw him alive on June 9, 1920,

and that death occurred, on the date stated above, at 10:50 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 4 mos. ds.

CONTRIBUTORY

Arterio-sclerosis

(Secondary)

unknown

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

No special test

(Signed)

J. F. Pessel.

M. D.

6-9, 1920 Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Carmel Cem.

6/12 1920

20 UNDERTAKER

ADDRESS

Chas. F. Evans & Son 118 W. 1st St. Baltimore

D43935

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D43935

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 W 36th)

ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elizabeth Keller

(a) RESIDENCE. NO. 612 W 36th

ST.: 13 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

6, 11, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Harry V Keller

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Bertha Keller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

Bertha Keller
612 W 36th St

15

Filed

Robert P. Harrison,

19

Registrar

JUN 12 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 11 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 11, 1920, to June 11, 1920.
that I last saw him alive on June 11, 1920.

and that death occurred, on the date stated above, at 11:40 P. M.

The CAUSE OF DEATH* was as follows:

Spontaneous Coronary
(Over much focus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Physical Examination

(Signed)

R. P. Harrison

M. D.

, 19 (Address)

3447 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Marys Hospital

June 12 1920

20 UNDERTAKER

ADDRESS

Chenoweth Son

D43936

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43936

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 N. Fremont St. ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Evelyn Moore

(a) RESIDENCE, NO.

1303 N. Fremont St. ST.

WARD.

Life Time

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

married

6 DATE OF BIRTH (month, day, and year)

1900

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto md

10 NAME OF FATHER

James Hack

11 BIRTHPLACE OF FATHER (city or town) (State or country)

md

12 MAIDEN NAME OF MOTHER

Ellen Ledger

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

11

Informant (Address)

Mrs Hack 1372 Calhoun St

15

Filed

12 1920Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1920

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1920 to June 9, 1920, that I last saw her alive on June 9, 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of lungsTuberculosis of lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Tuberculosis of lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) H. J. W. Kennard, M. D.6-11-1920 Address 708 Enoch St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt AuburnJune 12 1920

20 UNDERTAKER

ADDRESS

Edward Ringgold 1463 N. Bay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D43937

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1542 Woodyear St.* ST. *15* WARD)2-FULL NAME *William Lawson*(Residence in Baltimore: No. *1542 Woodyear St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed *2* 1926, by *P. Harrison,*

Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest*
(Inquest, au-topsy or inquiry.) and that said deceased came to death
on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. H. Hennessy* M. D.
(Coroner.)June 10, 1920 (Address) *2807 Edmundson Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Edward Ringgold *146371 Barry*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43938

CERTIFICATE OF DEATH.

79 ✓ D43938
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 N. Eden ST. 5 WARD)2-FULL NAME Hester Stoen

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 506 N. Eden St St.; 60 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, col. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, widow (Write the word.)6-DATE OF BIRTH, , 1860
(Month) (Day) (Year)7-AGE, 60 yrs., mos., ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) 9-BIRTHPLACE, (State or Country), 10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER (State or Country), 12-MAIDEN NAME OF MOTHER Hester Stoen13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Nodery(Address) 1725 Orleans St

15-

Filed 12 1920 Robert P. Harrison
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 11, 1920
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from 31-3-1920, to 11 June 1920, that I saw her alive on 10 u 1920, and that death occurred, on the date stated above, at 3 p.m.
The CAUSE OF DEATH* was as follows:Myocarditis, etc. etc.
Several ()
(Duration) yrs., mos., ds.CONTRIBUTORY (Secondary) Cardiac aneurysm
(Duration) yrs., mos., ds.(Signed) Elmerfield Boyd M. D.
12 June 1920 (Address) 475 N. Caroline St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.Where was disease contracted, if not at place of death? Former or usual residence 19-PLACE OF BURIAL OR REMOVAL, Laurel DATE OF BURIAL, June 14, 192020-UNDERTAKER John W. Henderson ADDRESS 1502 E. Monument

D43939

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43939

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Bond(a) RESIDENCE. NO. 232 S. Dallas St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs.

mos.

ds.

How long in U. S., if of foreign birth? Life yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

Black

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1892

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Laborer

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia,
(State or country) Pa.10 NAME OF FATHER Richard Bond11 BIRTHPLACE OF FATHER (city or town) Harford Co.
(State or country) Md.12 MAIDEN NAME OF MOTHER Janetta Brown13 BIRTHPLACE OF MOTHER (city or town) Harford Co.
(State or country) Md.

14

Informant Hospital Records(Address) New City Hospital.

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1920

17

I HEREBY CERTIFY, That I attended deceased from
June 4, 1920, to June 8, 1920,
that I last saw him alive on June 8, 1920,
and that death occurred, on the date stated above, at 7:05 P.m.

The CAUSE OF DEATH* was as follows:

Urinary infection
with gangrenous scrotum(duration) three days (?)

yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? unknownDid an operation precede death? yes Date of June 6, 1920Was there an autopsy? noWhat test confirmed diagnosis? operative findings
(Signed) Frank T. Barber M. D.June 8 1920 Address) New City Hospital*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Asbury
John W. HendersonJune 13 1920
1502
E. Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43940

CERTIFICATE OF DEATH.

X 93 D43940

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Protestant Inf. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. U P G St.; yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, married
(Write the word.)

6-DATE OF BIRTH, March 17, 1880
(Month) (Day) (Year)

7-AGE, 40 yrs. 2 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, clerk(b) General nature of industry, business, or establishment in which employed (or employer), 0099-BIRTHPLACE, (State or Country), W. Va.10-NAME OF FATHER, William Plumley11-BIRTHPLACE OF FATHER (State or Country), W. Va.12-MAIDEN NAME OF MOTHER, Sue Richmond13-BIRTHPLACE OF MOTHER (State or Country), W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Addie Plumley(Address) Hinton Street, W. Va.

15-

Robert P. Harrison,

JUN 12, 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 11, 1920, to June 12, 1920, that I saw him alive on June 12, 1920, and that death occurred, on the date stated above, at 1:05 P.M.

The CAUSE OF DEATH* was as follows:

Empyema (left chest)
(Duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary tuberculosis (Duration) yrs. mos. ds.

(Signed) J. H. Lamm, M. D.June 12, 1920 (Address) 641

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Hinton W. Va.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hinton Street, W. Va. June 12, 1920

20-UNDERTAKER

ADDRESS

Cal 502 & Oak

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43941

CERTIFICATE OF DEATH.

104 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

(Month) (Day) (Year)

7-AGE,

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-JUN 13 1920

ROBERT A. KAUFMAN

Filed..... 191.....

Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from June 11 1920, to June 12 1920, that I saw her alive on June 12 1920, and that death occurred, on the date stated above, at 7:35 A.M.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)(Signed)..... M. D.
June 12, 1920 (Address)..... Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? 2302 Ruskin Ave.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

D43942

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

b4
REGISTERED NO. C

D43942

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2702 Allan Ave ST.; 15 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2702 Allan Ave St.; 10 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)
6-DATE OF BIRTH, *Aug 20, 1884*
(Month) (Day) (Year)

7-AGE *35* yrs. *9* mos. *23* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Trained Nurse*
(b) General nature of industry, business, or establishment in which employed (or employer). *048*

9-BIRTHPLACE, (State or Country), *Balto Co*

10-NAME OF FATHER, *Char. L. Jessop*

11-BIRTHPLACE OF FATHER (State or Country), *Balto Co Md*

12-MAIDEN NAME OF MOTHER, *May Howard Polk*

13-BIRTHPLACE OF MOTHER (State or Country), *Balto Co Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Melan C Emerson*

(Address) *2702 Allan Ave*

15- JUN 13 1920 ROBERT I. LEATHER

Filed..... 191... *Baltimore* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 12, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 10 1920*, to *June 12 1920*, that I saw her alive on *June 11 1920*, and that death occurred, on the date stated above, at *12:30 am*.

The CAUSE OF DEATH* was as follows:
Hy pontatic Pneumonia following rapidly failing heart.

(Duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY *Cerebral Hemorrhage*
(Secondary)

(Signed) *James S. A. ...* M. D.
June 12, 1920 (Address) *4012 Park ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Sherrwood Church*

DATE OF BURIAL, *June 13, 1920*

20-UNDERTAKER, *W. R. Brooks*

ADDRESS, *Sparks ...*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43943

D43943

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2549 Marulloh ST. 13 WARD)2-FULL NAME Philip Weinstein(a) RESIDENCE. NO. 2549 Marulloh ST. 13 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 9 mos. 7 ds.How long in U. S., if of foreign birth? 18 yrs. 8 mos. 7 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofLeora Weinstein6 DATE OF BIRTH (month, day, and year) Unknown 1877

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

Presser9 BIRTHPLACE (city or town,
(State or country)) Russia10 NAME OF FATHER Shim Weinstein

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia12 MAIDEN NAME OF MOTHER Barley Jacobson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14

Informant
(Address)Jack Lewis
1411 E. Pratt St.

15

Filed

JUN 13 1920Barial Permit 10103

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-12 1920

17

I HEREBY CERTIFY, That I attended deceased from
May 1918, 1918, to June-3d, 1920,
that I last saw him alive on June 10th, 1920,
and that death occurred, on the date stated above, at
The CAUSE OF DEATH* was as follows:Diabetes Mellitus(duration) 3 yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Urine & blood examination(Signed) Herman Seidel, M. D.Pr. 1920 (Address) 1931 E Pratt St.*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Helms Boreale6-13-1920

20 UNDERTAKER

ADDRESS

Jack Lewis, 1411 E. Pratt St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital.

ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Brosnan

(a) RESIDENCE. NO. Unknown

ST. 26 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Indefinite mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE Years 72 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records

(Address) New City Hospital

15 JUNE 13 1920 ROBERT A. KATZ Registrar
Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1920

17 I HEREBY CERTIFY, That I attended deceased from February 4, 1888 to June 12, 1920, that I last saw him alive on June 11, 1920, and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Simple Glands (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No special test

(Signed) J. A. K. Katz, M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

\$ and 5th art Cu.

20 UNDERTAKER

Lilly and Jiles.

June 14 1920

ADDRESS

403 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D43945

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Balto Gen. Hospital* WARD)2-FULL NAME *Emmet Edmus Taylor*(a) RESIDENCE. No. *3125* *Abell* Ave. *SE*

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred *2* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan 5-1910*7 AGE Years *10* Months *5* Days *7* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address)

15 JUN 13 1920

ROBERT A. LAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *6-11-20*

17

I HEREBY CERTIFY, That I attended deceased from *6-5-20*, 19*20*, to *6-11-20*, 19*20*that I last saw him alive on *6-11-20*, 19*20*and that death occurred, on the date stated above, at *4:05 p.m.*

The CAUSE OF DEATH* was as follows:

= 1 = peritonitis(duration) yrs. mos. *2* ds.CONTRIBUTORY *Intestinal Obstruction* (Secondary)(duration) yrs. mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *6-9-11*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

R. R. Reynolds M.D. *6-11-20* (Address) *1213-1/2 Light St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oxford Maryland *Jan 14 1921*

20 UNDERTAKER

ADDRESS

William Cook *5026 North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43946

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43946

1-PLACE OF DEATH *Bon Secours Hospital* 20
 CITY OF BALTIMORE: (No. *Bon Secours Hospital* St.; *0* WARD)
 2-FULL NAME *Lanetta May Green*
 (Residence in Baltimore: No. *Bon Secours Hospital* St.; *0* yrs., *0* mos. *4* ds.)
Balt & Payson St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
 (Write the word.)
 6-DATE OF BIRTH, *May 9, 1860*
 (Month) (Day) (Year)
 7-AGE, *60 yrs. 1 mos. 3 ds.* If LESS than 1 day, ... hrs. or ... min.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *none 037*
 (b) General nature of industry, business, or establishment in which employed (or employer). *none*

9-BIRTHPLACE, (State or Country), *Minnesota*
 10-NAME OF FATHER, *Geo. Ruble*
 11-BIRTHPLACE OF FATHER (State or Country), *Pennsylvania*
 12-MAIDEN NAME OF MOTHER *Ellenora Umphrey*
 13-BIRTHPLACE OF MOTHER (State or Country), *Ohio*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr Townsend P. Green (husband)*
 (Address) *Shelbyville - Tennessee*

15- *ROBERT I. KRAUTER*
 Filed *JUN 13 1920* *Batist Permit: Q144*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 12, 1920*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 10* 1920, to *June 12* 1920, that I saw her alive on *June 12* 1920, and that death occurred, on the date stated above, at *7:30 P.*

The CAUSE OF DEATH* was as follows:

acute diffuse nephritis
pericarditis

(Duration) *about 1 month* yrs. mos. ds.

CONTRIBUTORY (Secondary) *uraemia*

(Duration) yrs. mos. ds.

(Signed) *J. A. Ward* M. D.

June 12, 1920 (Address) *144 Pulaski St. Baltimore Md*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *0* yrs. *0* mos. *4* ds. In the *0* yrs. *0* mos. *4* ds.

Where was disease contracted, if not at place of death? *Probably Tennessee*

Former or usual residence *Shelbyville - Tennessee*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Shelbyville - Tennessee *June 13, 1920*

20-UNDERTAKER
STEWART & MOWEN COMPANY
 (WILLIAM F. WOODEN, Successor)

ADDRESS
108 W. NORTH AVE.

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Enter statement of OCCUPATION if very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43947

D43947

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-JUN 13 1920

ROBERT I KRAUTER

Filed..... 191

BALTIMORE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at 12:00 P. m.

The CAUSE OF DEATH* was as follows:

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

(Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43948

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 Mulliken St. ST.; 6 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 1623 Mulliken St. St.; 7 yrs., 1 mos., 5 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married
(Write the word.)6-DATE OF BIRTH, May 7, 1899
(Month) (Day) (Year)7-AGE, 21 yrs., 1 mos., 5 ds. If LESS than 1 day,hrs. ormin.8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). 10379-BIRTHPLACE, (State or Country), Maryland10-NAME OF FATHER, Henry Counsel11-BIRTHPLACE OF FATHER (State or Country), Maryland12-MAIDEN NAME OF MOTHER, May Lee13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Shirley Meade(Address) 1623 Mulliken St.15- JUN 13 1920 191.....8-11-20

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH June 12, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 10, 1920, to June 12, 1920, that I saw her alive on June 11, 1920, and that death occurred, on the date stated above, at 1:35 a.m. The CAUSE OF DEATH* was as follows:Cholecystitis
(Duration).....yrs.....mos.....ds.CONTRIBUTORY Gastritis
(Secondary) (Duration).....yrs.....mos.....ds.(Signed) Richard L. Johnson, M.D.June 12, 1920 (Address) 1514 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Harford Co MdDATE OF BURIAL, June 13, 192020-UNDERTAKER, R B Gross 1405 M Elderry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter statement of OCCUPATION in very important. See instructions on back of certificate.

D43949

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43949

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Ave. & Barbara Ave.* ST. *26* WARD)

2-FULL NAME

N. Lillian Danielson

(a) RESIDENCE

No. *Franklin & Barbara Ave.* ST. *26* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct. 17th 1919*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *7 26*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) *Gardynville, Belts. Md.* (State or country) *Maryland*

10 NAME OF FATHER *Oluf Danielson*

11 BIRTHPLACE OF FATHER (city or town) *Sweden* (State or country) *Sweden*

12 MAIDEN NAME OF MOTHER *Johanna W. Wilhelm*

13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)

14 Informant *John P. Wilhelm* (Address) *Raspburg Md.*

15 Filed *JUN 13 1920* *ROBERT B. KAUTER* Registrar *Brail Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 13 1920*

17 I HEREBY CERTIFY, That I attended deceased from *June 6*, 1920, to *June 13*, 1920, that I last saw her alive on *June 12*, 1920, and that death occurred, on the date stated above, at *2200* a. m. The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

CONTRIBUTORY (Secondary) *Capillary Bronchitis* (duration) yrs. mos. ds. *10*

18 Where was disease contracted? *yes* If not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? (Signed) *George C. Long* M. D. 19 (Address) *27 Harford Rd*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Oak Lawn Cemetery* DATE OF BURIAL *June 15th 1920*

20 UNDERTAKER *Fredk. Loschmidt* ADDRESS *Falkenstein*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43950

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

152043950

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1656 E. 25th. ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ethel Elizabeth Trew

(a) RESIDENCE. NO.

1656 E. 25th.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

June 8, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

James Wilkins Trew

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Kent Co. Md.

12 MAIDEN NAME OF MOTHER

Ethel Angevine

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Fredrick, Md.

14

Informant

(Address)

Mr. John Dean
1656 E. 25th St.

15

Filed

JUN 13 1920

ROBERT K. LEAVITT

Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 12, 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 8, 1920, to June 12, 1920,that I last saw her alive on June 11, 1920,and that death occurred, on the date stated above, at 7:20 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

High Force Operation

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

No.

What test confirmed diagnosis?

(Signed)

R. H. Martin

M. D.

19

(Address)

4119 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Olivet Cemetery FrederickJune 14 1920

20 UNDERTAKER

ADDRESS

George F. Reith7354

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43951

1-PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO.

D43951

CITY OF BALTIMORE: (No. 15 ST.)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

ST. 15 WARD.

(If nonresident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female Black

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

67.

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

JUN 13 1920

ROBERT E. KLAUTER

Baptist Family Claret

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 16, 1920 to June 11, 1920, that I last saw her alive on June 11, 1920.

and that death occurred, on the date stated above, at 11:50 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminal)

CONTRIBUTORY (duration) yrs. mos. ds.

Secondary (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVIS

Approved by

Statement
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occupation

Baltimore, Md., June 15, 1920.

I do hereby make oath that the age of deceases, Willidina Mason,
given on Baltimore City Health Department Certificate of Death No. D43951
as 67 years is incorrect and that same should be 60 years.

D. Harry Gledhill
Physician.

Subscribed and sworn to before me this 15th day of June, 1920.

Reed Garth
Notary Public.

NTS

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CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Hks.

Harmon
D43952 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1333 N. Stricker St.* ST. *15* WARD)

2-FULL NAME

(a) RESIDENCE No. *1333 N. Stricker St.* ST. *15* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. mos. ds.

REGISTERED NO. *1920*
79 *D43952*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

colored

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1872

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

48

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Lloyd Harmon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

English Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

Geo Harmon 1333 N. Stricker St.

15

Filed

JUN 13 1920

Barial Permit Grant

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 11 1920

17 I HEREBY CERTIFY, that I attended deceased from

March 1 - 1920 to *June 11 1920*

that I last saw him alive on *June 7 1920*

and that death occurred, on the date stated above, at *11:40 p.m.*

THE CAUSE OF DEATH was as follows:

Valvular heart lesion

(duration) yrs. *4* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *W. J. Coleman* M. D.

, 19 (Address) *39 McCall St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

McCarroll

June 14 1920

20 UNDERTAKER

ADDRESS

Barrie & Wright 364 N. Carey

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43953

CERTIFICATE OF DEATH.

REGISTERED NO. C

D43953

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1623 Brent -

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1623 Brent -

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Caucasian

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH

June 12, 1920
(Month) (Day) (Year)

7-AGE

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE

(State or Country)

1623 Brent St. Balto

PARENTS.

10-NAME OF FATHER

Clarence Brooks

11-BIRTHPLACE OF FATHER

(State or Country)

Baltimore Md

12-MAIDEN NAME OF MOTHER

Lena Garrison

13-BIRTHPLACE OF MOTHER

(State or Country)

Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lena Brooks

(Address)

1623 Brent St

15-

JUN 13 1920

ROBERT B. ELSTON

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 12, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1920, to June 12, 1920,

that I saw him alive on June 12, 1920,

and that death occurred, on the date stated above, at 10 p.m.

The CAUSE OF DEATH* was as follows:

Normal Birth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

T. E. Sawyer M. D.

(Address)

June 12, 1920 (Address) 1602 Brent St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

M. A. Curran

June 14, 1920

20-UNDERTAKER

ADDRESS

Garrett Wright 1345 Maryland St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43951

CERTIFICATE OF DEATH.

108 D43951
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore Gen. Hospital WARD)

2-FULL NAME

Mary Hamzlik

(a) RESIDENCE. No. 2002 E. Madison ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (nr) WIFE of Chas. Hamzlik (hus)

6 DATE OF BIRTH (month, day, and year) 10/12/1885

7 AGE Years 36 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 637
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

10 NAME OF FATHER Jane Kudrna

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER W. Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Chas. Hamzlik
(Address) 2002 E. Madison St.

15 Filed JUN 13 1920 ROBERT E. KLAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1920

17 I HEREBY CERTIFY, That I attended deceased from 6/7 1920, to 6/11 1920, that I last saw him alive on 6/11 1920, and that death occurred, on the date stated above, at 1230 m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. ds. CONTRIBUTORY (Secondary) Acute Appendicitis
Peritonitis (duration) yrs. mos. ds. 4

18 Where was disease contracted if not at place of death? no

Did an operation precede death? yes Date of 6/8/20

Was there an autopsy? no

What test confirmed diagnosis? Operation
(Signed) R. R. Reynolds, M. D.

6/11, 1920 (Address) 1213 S. Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Mary's Cemetery June 14 1920

20 UNDERTAKER Frank Brock Co. ADDRESS 1906 Oakland

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 S. Bond ST.; 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 818 S. Bond St.; 24 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Wid

6-DATE OF BIRTH,

 1885
(Month) (Day) (Year)

7-AGE,

65 yrs., mos., ds.

If LESS than 1 day,

 hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House work
god9-BIRTHPLACE,
(State or Country),Poland

10-NAME OF FATHER,

Unknown11-BIRTHPLACE OF FATHER
(State or Country),Poland

12-MAIDEN NAME OF MOTHER

Unknown13-BIRTHPLACE OF MOTHER
(State or Country),Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Merle Sadowski(Address) 705 S. Ann St

15-

JUN 13 1920ROBERT I LAUTER

Filed

Barth P. Smith
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 12, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 28 1920, to June 12 1920, that I saw her alive on June 12 1920, and that death occurred, on the date stated above, at 7:20 p.m.
The CAUSE OF DEATH* was as follows:Acute Bronchitis(Duration) 2 yrs., mos., ds.CONTRIBUTORY
(Secondary)(Duration) 1 yrs., mos., ds.(Signed) H. Sadowski M. D.June 13, 1920 (Address) 722 S. Ann St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

June 15, 1920

20-UNDERTAKER

M. F. Sadowski

ADDRESS

705 S. Ann St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43956

CERTIFICATE OF DEATH.

104 D43956
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Nursery & Child's Hospital* ST.: *18* WARD)

2-FULL NAME

Thelma Mooney Lane
(Residence in Baltimore: No. *907 Harlem Ave.* St.: _____ yrs., *7* mos., *21* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

October 21, 1919
(Month) (Day) (Year)

7-AGE,

*7 yrs., 7 mos., 21 ds.*If LESS than 1 day,
....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....9-BIRTHPLACE,
(State or Country),*Baltimore md*10-NAME OF
FATHER,*L. H. Bottom*11-BIRTHPLACE
OF FATHER
(State or Country),*Richmond Va.*12-MAIDEN NAME
OF MOTHER*Lillian Mooney Lane*13-BIRTHPLACE
OF MOTHER
(State or Country),*Columbia S.C.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

W. H. Reckner

(Address),

1000 N. Fayette St.

15. JUN 13 1920

ROBERT A. KAUFER

Filed..... 191... *B-7-18-1920* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 11, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 6, 1920, to June 11, 1920,*that I saw her alive on *June 11, 1920,*and that death occurred, on the date stated above, at *1:10 P.M.*

The CAUSE OF DEATH* was as follows:

Acute Enterocolitis

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed).....

L. J. Feinglass M. D.*6-11, 1920* (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted,
if not at place of death?Former or
usual residence*907 Harlem Ave.*

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

June 18, 1920

20-UNDERTAKER

Geo. J. Smith

ADDRESS

1000 N. Fayette St.

Every item of information should be carefully supplied. Exact statement of OCCUPATION is important. See instructions on back of certificate.

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

D43957

CERTIFICATE OF DEATH

D43957

PLACE OF DEATH

CITY OF BALTIMORE (No. 4104 Penhurst Ave

ST. 15 WARD)

2-FULL NAME Robert E. Lee Sledge

(Residence in Baltimore: No. 4104 Penhurst Ave

St. 30 yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married (Write the word)

6. DATE OF BIRTH Feb 1, 1865 (Month) (Day) (Year)

7. AGE 55 yrs. 4 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Salesman 066

9. BIRTHPLACE (State or country) N.C.

10. NAME OF FATHER George R. Sledge

11. BIRTHPLACE OF FATHER (State or country) N.C.

12. MAIDEN NAME OF MOTHER Nancy Fleming

13. BIRTHPLACE OF MOTHER (State or country) N.C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Carrie L. Sledge

(Address) 4104 Penhurst Ave

15. ROBERT A. LAUTER

JUN 13 1920 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 11th, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3rd, 1918, to June 11th, 1920, that I saw him alive on June 11th, 1920, and that death occurred, on the date stated above, at 2⁰⁰ p. m. The CAUSE OF DEATH* was as follows:

Addison's Disease About (Duration) 2 yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Thomas L. Shearer M. D. June 12th, 1920 (Address) 905 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL June 15, 1920

20. UNDERTAKER George Smith ADDRESS 15 Gay St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-12—H. P. Co.—1000 Bks.

D43958

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43958

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Immunity Hospital* ST.: *28* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Paul Maybelle Meneffe*

(a) RESIDENCE. No. *Hickdale* Balto. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *18* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Quintus A. Meneffe*

6 DATE OF BIRTH (month, day, and year) *April 1 1879*

7 AGE Years *41* Months *2* Days *11* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Md.*
(State or country)

10 NAME OF FATHER *Francis W. Lawrence*

11 BIRTHPLACE OF FATHER (city or town) *Md.*
(State or country)

12 MAIDEN NAME OF MOTHER *Ann S. Appleby*

13 BIRTHPLACE OF MOTHER (city or town) *Md.*
(State or country)

14 Informant *Mrs. J. J. Moran*
(Address) *1003 N. Baltimore St.*

15 Filed *JUN 13 1920* *HOSPITAL PERMIT* *CLARK*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 17 1920*

17 I HEREBY CERTIFY, That I attended deceased from *June 10th*, 1920, to *June 12th*, 1920, that I last saw her alive on *June 12th*, 1920, and that death occurred, on the date stated above, at *2.30 P. m.* The CAUSE OF DEATH* was as follows:

Nephrotic Toxemia

(duration) yrs. mos. *7* ds.

CONTRIBUTORY *Pregnancy & labor*
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted *Home*
if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *renal laboratory*
(Signed) *Louis H. Dougherty*, M. D.

, 19 (Address) *12 York Street, Baltimore*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Lorraine Cemetery *June 5 1920*

20 UNDERTAKER ADDRESS *Joseph B. Cook* *1003 N. Baltimore St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Vera C. Albiker
HEALTH DEPARTMENT—CITY OF BALTIMORE

D43959

CERTIFICATE OF DEATH.

150 D43959
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 329 S. Fulton St.; 19 WARD)

2-FULL NAME

(Residence in Baltimore: No. 329 S. Fulton St.; yrs. 2 mos. 29 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female
4-COLOR OR RACE. white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
6-DATE OF BIRTH. Mar 14, 1920
(Month) (Day) (Year)

7-AGE. 2 yrs. 2 mos. 29 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.
10-NAME OF FATHER, Chas Albiker
11-BIRTHPLACE OF FATHER, Md.
12-MAIDEN NAME OF MOTHER, May Wachtman
13-BIRTHPLACE OF MOTHER, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Albiker
(Address) 329 S. Fulton Ave

15-
Filed JUN 13 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 12, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Mar 14, 1920, to June 12, 1920, that I saw her alive on June 12, 1920, and that death occurred, on the date stated above, at 49 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial closure of
Coronary Artery

(Duration) 2 yrs. 2 mos. 29 ds.
CONTRIBUTORY cardiac dilatation
(Secondary)

(Duration) 1 yr. 7 mos. 7 ds.
(Signed) H. E. Knapp M. D.
June 12, 1920 (Address) 1003 M. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery DATE OF BURIAL, June 14, 1920

20-UNDERTAKER, Joseph B. Cook ADDRESS, 1003 M. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43960

CERTIFICATE OF DEATH.

109

D43960

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin St. Hospital* ST. *20* WARD)2-FULL NAME *William M. Baldwin*

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. *1803 W. Mulberry* ST. *20* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *35* yrs. *9* mos. *10* ds.How long in U. S., if of foreign birth? *35* yrs. *9* mos. *10* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept 7 1874*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*35**9**10*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shirt Presser

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Standard Overall Co

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*10 NAME OF FATHER *William T. Baldwin*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Md.*12 MAIDEN NAME OF MOTHER *Mary A. Morrow*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

William T. Baldwin 1803 W. Mulberry Street

15

Filed

JUN 13 1920

DEPT. OF HEALTH

Registrar

DEPT. OF HEALTH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 12 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*June 10, 1920, to June 12, 1920*that I last saw him alive on *June 12, 1920*and that death occurred, on the date stated above, at *10 P. m.*

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction(duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *5* ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *yes* Date of *June 10/20*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Harston J. Parr*, M. D., 19 (Address) *Franklin St. Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park Bur**June 15 1920*

20 UNDERTAKER

*Joseph B. Cook*ADDRESS *1003 W. Balto Street*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43961

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43961

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Vincent Inf Asylum* ST. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Catherine Mary Kurwan*(Residence in Baltimore: No. *1401 Dinsin St* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *April 29, 1920*

(Month)

(Day)

(Year)

7-AGE, *14*

yrs.

mos.

da.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *none*
(b) General nature of industry, business, or establishment in which employed (or employer). *000*9-BIRTHPLACE, (State or Country), *Maryland*

PARENTS.

10-NAME OF FATHER, *Harvey Warner*11-BIRTHPLACE OF FATHER (State or Country), *unknown*12-MAIDEN NAME OF MOTHER, *Agnes Kurwan*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE,

(Informant) *Agnes Kurwan*(Address) *1401 Dinsin St*

15-

JUN 14 1920

ROBERT H. KRAUTER

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 12, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *April 10, 1920* to *June 12, 1920*, that I saw her alive on *June 10, 1920*, and that death occurred, on the date stated above, at *4:40* m.

The CAUSE OF DEATH* was as follows:

Cerebral
(Duration) yrs. mos. ds. *3*CONTRIBUTORY (Secondary) *Concussion*(Duration) yrs. mos. ds. *3*(Signed) *Oliver Helander* M. D.

1501 McNeill St. Baltimore, 101... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cathedral*DATE OF BURIAL, *June 14, 1920*20-UNDERTAKER, *Washburn & Sons*ADDRESS, *1827 W. North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43962

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43962

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Mary's Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Calverton

ST.

WARD)

2-FULL NAME

Mr. George Lee Bush

(a) RESIDENCE. NO.

Co'st P Mts. N. Va.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary Bush

6 DATE OF BIRTH (month, day, and year)

March 5 1864

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56

3

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

West Virginia

10 NAME OF FATHER

George M. Bush

11 BIRTHPLACE OF FATHER (city or town) (State or country)

West Virginia

12 MAIDEN NAME OF MOTHER

Mary M. Quinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

West Virginia

14

Informant (Address)

Mrs. Mary Bush Alice W. Va.

15

Filed JUN 14 1920

ROBERT A. LAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 12 1920

17

I HEREBY CERTIFY, that I attended deceased from

June 1st 1920 to June 12, 1920.

that I last saw him alive on June 12, 1920.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Inflammation of the Cauda Equina

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Yes

Date of June 12

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Alice West Va.

6/13 1920

20 UNDERTAKER

ADDRESS

Henry W. Mease & Son 805 N. Calver

via B. & O. R.R. - Mrs. Mary Bush - Escort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43963

CERTIFICATE OF DEATH.

D43963

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph Hosp* WARD)

2-FULL NAME

Mrs. Maria S. Oehm

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

1502 Mt. Royal St. WARD.

68 yrs.

mos.

ds.

How long in U. S., if of foreign birth? *68* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 30 1846

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

74

5

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

HW 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

John H. Biemiller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Maria S. Leing

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant

(Address)

Arthur Oehm 1502 Mt. Royal Ave

15

JUN 14 1920

ROBERT R. KRAUTER

Barial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 11 1920

17

I HEREBY CERTIFY, That I attended deceased from

6-7-20, 19, to *6-11-20*, 19

that I last saw him alive on *6-11-20*, 19

and that death occurred, on the date stated above, at *10 a. m.*

The CAUSE OF DEATH* was as follows:

myocardial infarct

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

cholecystitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

2

Did an operation precede death? *yes* Date of *6/8/20*

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

F. C. Marnett, M. D.

(Address) *St. Joseph Hosp*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cemetery

June 14 1920

20 UNDERTAKER

ADDRESS

B. Schuman & Son

London Park Cemetery

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43961

CERTIFICATE OF DEATH.

D43961

1-PLACE OF DEATH

Southern Hospital

REGISTERED No. C

CITY OF BALTIMORE: (No.

Greenmount Ave. 2512

ST. 13

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Ella Virginia Reese

(Residence in Baltimore: No.

854 W. North Ave.

St.; 67 yrs., 11 mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

July

(Month)

(Day)

1853 (Year)

7-AGE,

67

yrs.

11

mos.

ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Sales lady
Department Store

9-BIRTHPLACE,

(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

William H. Reese

11-BIRTHPLACE OF FATHER

(State or Country),

Balto. Md.

12-MAIDEN NAME OF MOTHER

Alegina Bucking

13-BIRTHPLACE OF MOTHER

(State or Country),

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis W. Bridges

(Address) 1945 University Ave.

15-

Filed

JUN 14 1920

191

ROBERT I. KRAUTER

Burial Park

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 12

(Month)

12

(Day)

1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 12 1920, to June 12 1920,

that I saw her alive on June 8 1920,

and that death occurred, on the date stated above, at 6:45 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(Duration) yrs. 6 mos. 8 ds.

CONTRIBUTORY (Secondary) Carcinomatous

(Duration) yrs. 3 mos. ds.

(Signed) Henry L. Houser, M. D.

June 12 1920 (Address) 1011 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. 5 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park

June 14, 1920

20-UNDERTAKER

ADDRESS

John Ditchell 1201 W. Fayette

D43965

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

122 D43965

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 W. Monument ST.; 11 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Vanderpool Newcomer

(s) RESIDENCE. No. 105 W. Monument ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed or Divorced (write the word) Married

5a If married, widowed or divorced, HUSBAND of (or) WIFE of Waldo Newcomer

6 DATE OF BIRTH (month, day, and year) 1870-12-10

7 AGE Years 49 Months 6 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lady at ood

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town) New York (State or country) N.Y.

10 NAME OF FATHER Aaron Vanderpool

11 BIRTHPLACE OF FATHER (city or town) New York (State or country) New York

12 MAIDEN NAME OF MOTHER Adeline Van Schraack

13 BIRTHPLACE OF MOTHER (city or town) New York (State or country) New York

14 Informant Mr. Waldo Newcomer (Address) 105 W. Monument

15 Filed JUN 14 1920 ROBERT E. KAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1919, to June 11, 1920, that I last saw him alive on June 11, 1920, and that death occurred, on the date stated above, at 7:45 p.m. The CAUSE OF DEATH* was as follows:

Chronic pyelonephritis

(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY Anemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Charcot's urine test

(Signed) James F. Friedman, M. D.

19 (Address) 1034 Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cln

6-14 1920

20 UNDERTAKER

ADDRESS

Henry W. Watkins & Sons Co

McFulloch Orchard

Information should be carefully supplied. NAME SHOULD BE PRINTED. Exact statement of OCCURRENCE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43966

CERTIFICATE OF DEATH.

136 D43966

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST.; 18 WARD)

2-FULL NAME

Beatrice Hosley Johnson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 244 N SchroederSt.; 21 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. 2 4-COLOR OR RACE, C 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married
(Write the word.)6-DATE OF BIRTH, Jan 31, 1899
(Month) (Day) (Year)7-AGE, 21 yrs., 4 mos., 12 ds. If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 0379-BIRTHPLACE, (State or Country), Balti City10-NAME OF FATHER, Albert Hosley11-BIRTHPLACE OF FATHER (State or Country), Pa12-MAIDEN NAME OF MOTHER Lillian Mikes13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian Hosley(Address) 244 N Schroeder

15-JUN 14 1920

ROBERT E. KAUTER

191

BALTIMORE CITY

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 12, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 30 1920, to June 12 1920, that I saw him alive on June 12 1920, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Contracted pelvis & pregnancy(Duration) 9 yrs., 9 mos., ds.CONTRIBUTORY (Secondary) Cesarean Section(Duration) 12 yrs., mos., ds.(Signed) J. McRae M. D.June 12, 1920 (Address) 739 George

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. AuburnDATE OF BURIAL, June 13, 1920

20-UNDERTAKER

ADDRESS 143John H. Treadwell

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. See instructions on back of certificate.

D43967

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1531* *High* ST. *24* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Chas A. Hammond Jr.

(a) RESIDENCE. NO.

1531 High ST. *24* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar 11/1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1**4**2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balti.

10 NAME OF FATHER

Chas A. Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balti.

12 MAIDEN NAME OF MOTHER

Robert Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balti.

14

Informant (Address)

Chas A. Hammond
1531 High St

15

Filed

JUN 14 1920

JOSEPH E. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 13 1920

17

I HEREBY CERTIFY, That I attended deceased from

*Jun 1, 1920, to Jun 13, 1920*that I last saw him alive on *Jun 13, 1920*and that death occurred, on the date stated above, at *6 P* m.

The CAUSE OF DEATH* was as follows:

*Measles*CONTRIBUTORY (Secondary) *Broncho Pneumonia* (duration) yrs. mos. *13* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinically*(Signed) *R. E. Campbell* M. D.Address *1644 Hammond St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**June 15 1920*

20 UNDERTAKER

ADDRESS

Whitfield 1200 N. Lombard

Information should be carefully supplied. Age should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-12 H. P. Co. 1000 Ills.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43968

CERTIFICATE OF DEATH.

42

D43968

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 E. Preston ST.: 9 WARD)

2-FULL NAME Mary Ella Creamer

(a) RESIDENCE. No. 731 E. Preston ST.: 9 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sam'l - Krum

6 DATE OF BIRTH Dec 2 1859 (month, day, and year)

7 AGE 60 Years 6 Months 10 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bullet hole maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Wm E D. Perego

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna M. Camper

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant David J. Krum (Address) 720 E. Preston

15 Filed JUN 14 1920 BOBET E. KRAUTER Registrar Boris P. O'Brien

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1920

17 I HEREBY CERTIFY, That I attended deceased from June, 1919, to July 12, 1920. That I last saw him alive on July 12, 1920, and that death occurred, on the date stated above, at 4 p. m. The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(duration) 1 yr. 1 mos. ds. CONTRIBUTORY Exhaustion (Secondary) (duration) yrs. mos. ds. 10

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 1 1919 Was there an autopsy? No.

What test confirmed diagnosis? (Signed) John H. Robinson M. D. 19 (Address) 712 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Sanctum Ridge June 14 1920 20 UNDERTAKER ADDRESS Wm Cork 144 1406

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43969

D43969

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 N. Fremont ST.; 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Andrew Marie Miller(a) RESIDENCE. NO. 519 N. Fremont ST., 17 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? 3 yrs. 3 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) Feb 22 19207 AGE Years — Months 3 Days 21 If LESS than 1 day, hrs. — or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —(b) General nature of industry, business, or establishment in which employed (or employer) —(c) Name of employer —9 BIRTHPLACE (city or town) Baltimore City (State or country)10 NAME OF FATHER John O. Miller11 BIRTHPLACE OF FATHER (city or town) Annapolis Md (State or country)12 MAIDEN NAME OF MOTHER Matilda S. Carls13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)14 Informant John O. Miller (Address) 519 N. Fremont St.15 Filed JUN 14 1920 JOHN O. MILLER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 192017 I HEREBY CERTIFY, That I attended deceased from June 12, 1920, to June 13, 1920, that I last saw her alive on June 12, 1920, and that death occurred, on the date stated above, at 8 30 a m.

The CAUSE OF DEATH* was as follows:

Acute Diphtheria & Intestitis(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.18 Where was disease contracted Home if not at place of death?Did an operation precede death? no Date of —Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. Moore, M. D.19 Address 1520 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

WesternJune 14 1920

20 UNDERTAKER

Geo W Little531 N. Fremont St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43970

CERTIFICATE OF DEATH.

D43970

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2805 Guilford Ave* ST. *150* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *2805 Guilford Ave* ST. *150* WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. *6* mos. *5* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

JUN 14 1920

ROBERT B. KRAUTER Registrar

BALTIMORE PERMIT OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 12* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from *Sept*, 19*05*, to *June 12*, 19*20*.that I last saw h. alive on *June 12*, 19*20*.and that death occurred, on the date stated above, at *5:30 p* m.

The CAUSE OF DEATH* was as follows:

Congenital cystic kidney(duration) *15* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *no*What test confirmed diagnosis? *Urinal examination*(Signed) *John B. Spence* M. D., 19 (Address) *The Tavern, Carter street*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Greenmount**June 14* 19*20*

20 UNDERTAKER

ADDRESS

*John B. Spence**1325 Broadway*

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST.: *8th* WARD)

2-FULL NAME

Ruth Walter

(a) RESIDENCE. NO.

1235 N. Caroline St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

2 yrs

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Infant

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

Nov. 26 1919

7 AGE

Years

Months

Days

6

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Maryland

(State or country)

10 NAME OF FATHER

Harry Walter

11 BIRTHPLACE OF FATHER (city or town)

Maryland

(State or country)

12 MAIDEN NAME OF MOTHER

Maisy Schaffert

13 BIRTHPLACE OF MOTHER (city or town)

M. D.

(State or country)

14

Informant

(Address)

Hospital Record

26. 26.

JUN 14 1920

ROBERT B. KRAUTER

Registrar

Serial Permit 0101

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 11 1920*

17

I HEREBY CERTIFY, That I attended deceased from

May 28, 19*20*, to *June 11*, 19*20*.

that I last saw her alive on *June 11*, 19*20*.

and that death occurred, on the date stated above, at *10:00* m.

The CAUSE OF DEATH* was as follows:

*Congenital Debility
(Mongolism)*

(duration) yrs. *7* mos. *4* ds.

CONTRIBUTORY

(Secondary)

infusional

(duration) yrs. mos. *17* ds.

18 Where was disease contracted

if not at place of death?

home

Did an operation precede death? *yes* Date of *May 29, 1920*

Was there an autopsy?

yes -

What test confirmed diagnosis?

(Signed) *Harold L. Higgins*, M. D.

6/12. 1920 Address *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery June 14 1920

20 UNDERTAKER

Robert J. Turner

ADDRESS

1424 Broadway

maison should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D43972

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43972

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Worley(a) RESIDENCE. No. 1638 E. Federal St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

Female

White

Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1884

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

35

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work Housework(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,

(State or country)

Md.

10 NAME OF FATHER

Charles Worley

11 BIRTHPLACE OF FATHER (city or town)

Maryland

(State or country)

12 MAIDEN NAME OF MOTHER Liza Work

June 13 1920

(Address)

New City Hospital.

13 BIRTHPLACE OF MOTHER (city or town)

Unknown

(State or country)

14

Informant Hospital Records

(Address)

New City Hospital.

15

Filed JUN 14 1920ROBERT R. KRAUTER
Registrar

Baltimore Health Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 8, 1920, to June 12, 1920.that I last saw him alive on June 11, 1920.and that death occurred, on the date stated above, at 8:30 A.m.

The CAUSE OF DEATH* was as follows:

Epidemic Cerebro-Spinal
Meningitis(duration) yrs. 1 1/2 mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?CityDid an operation precede death? no Date ofWas there an autopsy? yes

What test confirmed diagnosis?

(Signed)

J. P. Pessel

M. D.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Balto CemeteryJune 14 1920

20 UNDERTAKER

Robt J Turner

ADDRESS

1442 N Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43973

CERTIFICATE OF DEATH.

66 D43973

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St.; 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 54 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Widower

6-DATE OF BIRTH,

Sept. 16, 1846
(Month) (Day) (Year)

7-AGE,

74 yrs., 9 mos., ds.

If LESS than 1 day,
hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Clerk 009
(Dry Goods)9-BIRTHPLACE,
(State or Country),

Germany

10-NAME OF FATHER,

John Smith

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Elizabeth Smith

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

George J. Joesel

(Address),

217 S. Penn.

15-

Filed

JUN 14 1920

191

ROBERT A. KRAUTER

DEPT. OF HEALTH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 16, 1920, to June 4, 1920, that I saw him alive on June 4, 1920, and that death occurred, on the date stated above, at 12 a. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY

(Secondary)

Attack of Hemiplegia (Duration) 10 yrs., mos., ds.

(Signed)

Marshall G. Smith

M. D.

June 13, 1920 (Address) 1184 Calhoun St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Cem. June 14, 1920

20-UNDERTAKER

ADDRESS

For Joesel's Son, 217 S. Penn.

Exact statement of OCCUPATION, CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43974

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 33 Bernad ST. 17 WARD)

2-FULL NAME

(a) RESIDENCE.

(Usual place of abode)

Length of residence in city or town where death occurred

3

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

3

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Adon Pacemaker

6 DATE OF BIRTH (month, day, and year)

Sep 19 1848

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

79

8

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant Address

J E Pacemaker 28 33 Bernad St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 12 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 8 1920 to June 12 1920

that I last saw her alive on June 12 1920

and that death occurred, on the date stated above, at 11 P.m.

The CAUSE OF DEATH* was as follows:

Paralysis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J E Pacemaker M. D.

1920

Address

1124 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Marys Hospital June 14 1920

20 UNDERTAKER

Chenoweth Son Chestnut

JUN 14 1920

ROBERT B. T. T. T.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D43975

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43975

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 Hayward Ave 27 WARD)

2-FULL NAME

William P Rustic

(a) RESIDENCE. No. 209 Hayward Ave

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Elizabeth Rustic

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

At Builders

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md

10 NAME OF FATHER

Wm Rustic

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Arlington Md

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Elizabeth Rustic 209 Hayward Ave

JUN 14 1920

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 13 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 1, 1920, to June 13, 1920,

that I last saw him alive on June 13, 1920,

and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(duration) yrs. 3 mos. ds.

CONTRIBUTORY

(Secondary)

Nephritis

(duration) 1 yrs. 6 mos. — ds.

18 Where was disease contracted

if not at place of death? at Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Dr. S. Weller, M. D.

, 19 (Address) Arlington Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral June 13 1920

20 UNDERTAKER

ADDRESS

Cherowith Son Chestnut St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43976

D43976

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *730 Greenmount Ave* ST *10* WARD)

2-FULL NAME *Oscar P F Wehmann*

(a) RESIDENCE. NO. *730 Greenmount Ave* RD.

(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? *50* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Amelie Wehmann*

6 DATE OF BIRTH (month, day, and year) *Nov 30 1885*

7 AGE Years *64* Months *6* Days *12* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Shoemaker*

(b) General nature of industry, business, or establishment in which employed (or employer) *088*

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany* (State or country)

10 NAME OF FATHER *Jacob Wehmann*

11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)

12 MAIDEN NAME OF MOTHER *Minnie Krebs*

13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)

14 Informant *Amelie Wehmann* (Address) *730 Greenmount*

15 *JUN 14 1920* *ROBERT E. KRAUTER* Registrar *Basal Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 11 1920*

17 I HEREBY CERTIFY, That I attended deceased from *Apr 9*, 19*19*, to *June 11*, 19*20*, that I last saw him alive on *June 9*, 19*20*, and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) *3* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Chronic Rheumatism*

(duration) *4* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *John F. Beck* M. D.

6/14, 19*20* (Address) *936 E. Monument*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Loudon Park* DATE OF BURIAL *June 14 1920*

20 UNDERTAKER *Willard B. Callender* ADDRESS *Bank & Ann St*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43977

CERTIFICATE OF DEATH.

40

D43977

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.

WARD)

2-FULL NAME John Smith.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. Unknown

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

40

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14

Informant Hospital Records
(Address) New City Hospital.

15

JUN 14 1920 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1920

17

I HEREBY CERTIFY, That I attended deceased from May 25, 1920 to June 8, 1920, that I last saw him alive on June 8, 1920, and that death occurred, on the date stated above, at 9:55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

Metastases to Liver

(duration) yrs. 1+ mos. ds.

18 Where was disease contracted if not at place of death? Ch

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No special test

(Signed) J. P. Pessel

M. D.

June 9, 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF ~~INTERMENT~~ CREMATION ~~_____~~

DATE OF BURIAL

Bay View Hospital

6-11-1920

20 UNDERTAKER

ADDRESS

J. B. Hunter

1517 N

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43978

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Lowson

(a) RESIDENCE. NO.

Sparrow Pt Md

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, 0 hrs. or 0 min.

*0**0**7*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

George Lowson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant (Address)

R. Johnston

15

File

*JUN 14 1920**ROBERT E. KRAUTER*

Registrar

Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 10 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 3, 19*20*, to *June 10*, 19*20*,that I last saw him alive on *June 10*, 19*20*,and that death occurred, on the date stated above, at *5⁰⁰ P. m.*

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of —Was there an autopsy? *yes*

What test confirmed diagnosis?

(Signed) *John W. Harris*, M. D.Address *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Health.

ADDRESS

JUN 14 1920

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43979

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43979

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Christo Institution Hospital, 170*
CITY OF BALTIMORE: (No. *704 Ensor St* ST.: *17* WARD)
2-FULL NAME *Violet Giggotts*
(a) RESIDENCE. No. *710 W. Mulberry* ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred *26* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *col* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*
5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Wm Giggotts*
6 DATE OF BIRTH (month, day, and year) *Unknown*
7 AGE Years *40* Months *-* Days *-* If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work *at home*
(b) General nature of industry, business, or establishment in which employed (or employer) *ooo*
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Va*
10 NAME OF FATHER *Wm Giggotts*
11 BIRTHPLACE OF FATHER (city or town) (State or country) *Va*
12 MAIDEN NAME OF MOTHER *Unknown*
13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Va*

14 Informant *Mary Giggotts*
(Address) *710 W. Mulberry St*

15 Filed *JUN 14 1920* *ROBERT I. KRAUTER*
Bacial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 11 1920*
17 I HEREBY CERTIFY, That I attended deceased from *April 12, 1920, to June 11, 1920,*
that I last saw her alive on *June 11, 1920,*
and that death occurred, on the date stated above, at *8.30 A. m.*
The CAUSE OF DEATH* was as follows:
apoplexy - Bright Disease - complication of disease
(duration) yrs. mos. ds. *3*
CONTRIBUTORY *Bright Disease*
(Secondary) (duration) yrs. mos. ds. *9*

18 Where was disease contracted if not at place of death?
Did an operation precede death? *no* Date of
Was there an autopsy? *no*
What test confirmed diagnosis?
(Signed) *Dr. W. Kennard* M. D.
611, 1920 Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *McAuliffe Inty* DATE OF BURIAL *June 18 1920*
20 UNDERTAKER *Mrs Robert A Elliott* ADDRESS *725-9thlandm*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43980

CERTIFICATE OF DEATH.

D43980

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 322 N Carey ST. 19 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 322 N Carey ST. 19 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

56 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 26-18767 AGE Years 63 Months 3 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

JUN 14 1920

ROBERT A. KAUTER Registrar

Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12th 192017 I HEREBY CERTIFY, That I attended deceased from June 11th, 1920, to June 12th, 1920, that I last saw him alive on June 11th, 1920, and that death occurred, on the date stated above, at 12.20 a.m.The CAUSE OF DEATH* was as follows:
Anterior Sclerosis
(duration) 6 yrs. 6 mos. 6 ds.
CONTRIBUTORY Angina Pectoris
(Secondary) (duration) 1 yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Joseph E. Deane, M. D., 19 (Address) 3055 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

WilliamJune 14 1920

20 UNDERTAKER

ADDRESS

St. LawrenceNotre Dame

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43981

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D43981

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *552 McMechen* ST. *14* WARD)

2-FULL NAME *William M. Cronie*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. *552 McMechen* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *60* yrs. mos. ds. How long in U. S., if of foreign birth? *60* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced, HUSBAND of *Harriet E. Cronie* (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Mar. 9th 1838*

7 AGE Years *81* Months *4* Days *23* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *retired*

(b) General nature of industry, business, or establishment in which employed (or employer) *Shoemaker*

(c) Name of employer

9 BIRTHPLACE (city or town) *Ireland* (State or country)

10 NAME OF FATHER *unknown*

11 BIRTHPLACE OF FATHER (city or town) *Ireland* (State or country)

12 MAIDEN NAME OF MOTHER *unknown*

13 BIRTHPLACE OF MOTHER (city or town) *Ireland* (State or country)

14 Informant *Harriet E. Cronie* (Address) *552 McMechen St.*

15 JUN 14 1920

ROBERT F. LEATHER Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 12th 1920*

17 I HEREBY CERTIFY, That I attended deceased from *June 10*, 1920, to *June 12*, 1920, that I last saw him alive on *June 12*, 1920, and that death occurred, on the date stated above, at *10* m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. *3* ds. CONTRIBUTORY *arterio-sclerosis* (Secondary) (duration) *15* yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*

Did an operation precede death? — Date of —

Was there an autopsy? *No*

What test confirmed diagnosis? *Chemical* (Signed) *Chas. P. Clauton, M. D.*

(Address) *1504 McMechen St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park *6-15 1920*

20 UNDERTAKER ADDRESS

Graham F. Walker, 7234 1/2 Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Josephs Hospital* ST.: *9* WARD)2-FULL NAME *Bertha Blaney*(a) RESIDENCE. NO. *1625 Emor St.* ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *35* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced
HUSBAND or (or) WIFE of *Geo W. Blaney*6 DATE OF BIRTH (month, day, and year) *Oct 19 1873*7 AGE Years Months Days *abt. 47* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*(b) General nature of industry, business, or establishment in which employed (or employer) *037*

(c) Name of employer

9 BIRTHPLACE (city or town) *Penna*
(State or country)10 NAME OF FATHER *Geo W. Eby*11 BIRTHPLACE OF FATHER (city or town) *Penna*
(State or country)12 MAIDEN NAME OF MOTHER *Mary J. Eby*13 BIRTHPLACE OF MOTHER (city or town) *Penna*
(State or country)14 Informant *Geo W. Blaney*
(Address) *1625 Emor*15 Filled *ROBERT A. KAUTER* Registrar

JUN 14 1920

Burial Permit *0107*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 13 1920*17 I HEREBY CERTIFY, That I attended deceased from *June 10 1920*, to *June 13 1920*, that I last saw her alive on *June 13 1920*, and that death occurred, on the date stated above, at *5:20* m.

The CAUSE OF DEATH* was as follows:

*Heart Strokes*CONTRIBUTORY (Secondary) *Surge of Shock* (duration) yrs. mos. ds.18 Where was disease contracted
If not at place of death?Did an operation precede death? *Yes* Date of *June 12/20*Was there an autopsy? *No*What test confirmed diagnosis? *Operation*
(Signed) *Charles J. Cook*, M. D.June 1920 (Address) *St Josephs Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore *June 17 1920*

20 UNDERTAKER ADDRESS

William Cook *502 E North*mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUR-
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state
mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43981

D43981

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 Kennedy Ave. ST., 9 WARD)

2-FULL NAME

Fred L. Haile

(a) RESIDENCE

No. 1906 Kennedy ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Marion C. Haile

6 DATE OF BIRTH (month, day, and year)

Oct 10 - 1860

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

59

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Police Officer

(b) General nature of industry, business, or establishment in which employed (or employer)

City of Balto

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Hyde Maryland

10 NAME OF FATHER

Charles J. Haile

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Hyde Maryland

12 MAIDEN NAME OF MOTHER

Nellie L. Deets

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Hyde Maryland

14

Informant (Address)

Marion C. Haile
1906 Kennedy Ave.

15

JUN 14 1920

ROBERT A. KRAUTER

Notary Public

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 13 1920

17

I HEREBY CERTIFY, That I attended deceased from June 12, 1920, to June 13, 1920, that I last saw him alive on June 13, 1920, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Ileus.
(Paralysis of Bowels)
duration 3 hrs.

CONTRIBUTORY (Secondary)

Chronic Nephritis.
duration 1 yrs. 3 (recorded)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Squashed Microscope

(Signed)

Frederick A. Bailey, M. D.

6/13, 1920 (Address)

3849 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Woodlawn

DATE OF BURIAL

6/16 1920

20 UNDERTAKER

Wm Cook

ADDRESS

502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43985

CERTIFICATE OF DEATH.

18

D43985

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 Whitridge ST. W3 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 419 Whitridge ST. W3 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Alfred Wendle

6 DATE OF BIRTH (month, day, and year)

29 / 12 / 1824

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

96

1

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

New York

New York

10 NAME OF FATHER

James Gauston

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N. Y.

12 MAIDEN NAME OF MOTHER

Margaret Polyzona

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N. Y.

14

Informant (Address)

Jessie Trundle

419 Whitridge Ave

15

FILE JUN 14 1920

ROBERT F. BRADLEY

via B & G. R. A. - 10 Arthur W. Trundle

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6/13 1920

17

I HEREBY CERTIFY, That I attended deceased from

1/12/20, 19

to 6/13/20, 19

that I last saw him alive on

6/13/20

and that death occurred, on the date stated above, at

7:30 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Erysipelas

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical only

(Signed) Philip S. Towler, M. D.

(Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Washington L.O.C.

June 15 1920

20 UNDERTAKER

William Cowie

ADDRESS

508 North Ave

D43986

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43986

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *1014 N. Carey* ST. *16* WARD)FULL NAME *Frank Chandler*(Residence in Baltimore: No. *1014 N. Carey St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

black

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

married

6-DATE OF BIRTH,

*August**10**1895*

(Month)

(Day)

(Year)

7-AGE,

*35**10**1*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER,

(State or Country).

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER,

(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*June**11*, 19*20*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Free moved (Lobar)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *J. N. Harrison* M. D.*June 12* 19*20* (Address) *2802 Edmondson*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, DATE OF BURIAL,

Edwin O. Ringgold *June 11*, 19*20*

20-UNDERTAKER ADDRESS

Mr. Auburn *1463 Carey*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 14 1920

No influenza

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges,*

peritoneum, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, Hæmorrhage, Meningitis, Phlebitis, Cellulitis, Gangrene, Miscarriage, Pyæmia, Childbirth, Gastritis, Necrosis, Septicæmia, Convulsions, Erysipelas, Peritonitis, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to same.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-3-19—H. P. Co.—1000 Hks.

D43987

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43987

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

Mt Hope Reformatory

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sadie M. Kelly

(a) RESIDENCE. NO.

(Usual place of abode)

484 Cranford Ave Jersey City N.J.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

4 yrs.

0 mos.

0 ds.

Now long in U. S., if of foreign birth?

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 1890

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Charleston S.C.

10 NAME OF FATHER

Michael Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Montreal Canada

12 MAIDEN NAME OF MOTHER

Margt M. Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Jersey City N.J.

14 Informant (Address)

Records of Mt Hope Reformatory

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 13 1920

17

I HEREBY CERTIFY, That I attended deceased from

Sept

1916

to June 13th 1920.

that I last saw him alive on

June 20th 1920.

and that death occurred, on the date stated above, at

2.50 P. m.

The CAUSE OF DEATH* was as follows:

Gasno Exhilaration

Abt

(duration) *0* yrs. *1* mos. *0* ds.

CONTRIBUTORY (Secondary)

Terminal Dementia - Post Ch.

Neurasthenia

(duration) *4* yrs. *0* mos. *0* ds.

18 Where was disease contracted

If not at place of death? *Jersey City - N.J.*

Did an operation precede death?

No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Frank J. Flannery* M. D.

June 13 1920 (Address) *Mt Hope Reformatory*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Jersey City N.J.

June 14th 1920

20 UNDERTAKER

Henry W. Jenkins & Sons Co

ADDRESS

Orchard Mead

D43988

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43988

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 E. Baltimore St ST.; 6 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1604 E. Baltimore St St. 25 yrs., 1 mos., 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, Widowed
MARRIED, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, April 30, 1940
(Month) (Day) (Year)7-AGE, 80 yrs., 1 mos., 14 ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, House work
(b) General nature of industry, business, or establishment in which employed (or employer) do9-BIRTHPLACE, (State or Country), Bavaria, Germany10-NAME OF FATHER, John Bruckner11-BIRTHPLACE OF FATHER (State or Country), Bavaria, Germany12-MAIDEN NAME OF MOTHER not known13-BIRTHPLACE OF MOTHER (State or Country), Bavaria, Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Dreyer(Address) 1604 E. Baltimore St

15-

JUN 14 1920 Robert P. Harrison,
191..... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 14, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 10 1919, to June 14 1920,
that I saw her alive on June 13 1920,
and that death occurred, on the date stated above, at 9:20 a.m.
The CAUSE OF DEATH* was as follows:
Cardiac Failure..... (Duration) yrs. mos. ds.
CONTRIBUTORY Chronic Interstitial Nephritis
(Secondary) Chronic Interstitial Nephritis
..... (Duration) yrs. mos. ds.
(Signed) Richard D. Cashman M. D.
June 14, 1920 (Address) 1514 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Baltimore City June 16, 1920

20-UNDERTAKER ADDRESS

Louis Heermann 328 Broad
way

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43989

D43989

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 Wider ST.; 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William Davis(Residence in Baltimore: No. 610 Wider alley St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Caucasian5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH

June 2, 1893
(Month) (Day) (Year)

7-AGE,

28 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Sabot
(b) General nature of industry, business, or establishment in which employed (or employer). 040

9-BIRTHPLACE, (State or Country),

St. L.

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER (State or Country),

unknown

12-MAIDEN NAME OF MOTHER

Anna Rosefort

13-BIRTHPLACE OF MOTHER (State or Country),

St. L.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) May Russell(Address) 610 Wider alley

15-

Robert P. Harrison

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 11, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 4, 1920, to June 11, 1920,that I saw him alive on June 11, 1920,and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Infarction of the heartdue to atheroma(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.(Signed) W. H. Harrison M. D.June 11, 1920 (Address) 712 S. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Rock Hill Station

19-PLACE OF BURIAL OR REMOVAL,

Rock Hill S. L.

DATE OF BURIAL,

June 14, 1920

20-UNDERTAKER

Charles B. Jones 241 Pine

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 4 1920

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D43990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 ✓ D43990
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 326 E. 27th ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bridget Kennedy

(Residence in Baltimore: No. 326 E. 27th St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)

6-DATE OF BIRTH, June 12, 1843
(Month) (Day) (Year)

7-AGE, 77 yrs., 0 mos., 0 ds. It LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer) ooo

9-BIRTHPLACE, (State or Country), Ireland.

10-NAME OF FATHER, Patrick Harrigan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catharine Digney

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Yager
(Address) 326 E. 27th St.

15- Robert P. Harrison,
Jun 14 1920 191..... Registrar.

16- Robert P. Harrison,
Jun 14 1920 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 12, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15, 1920, to June 12, 1920, that I saw her alive on June 11, 1920, and that death occurred, on the date stated above, at 12 P.m. The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(Duration) 1 yrs., 6 mos., 0 ds.
CONTRIBUTORY (Secondary).....
(Duration)..... yrs., mos., ds.

(Signed) C. J. Davies M. D.
6/12, 1920 (Address) 220 W. 33rd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Catharine's DATE OF BURIAL, 6/15, 1920

20-UNDERTAKER, J. J. Moran ADDRESS 3000 E. Baltimore

D43991

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 Ridgely ST. 21 WARD)

2-FULL NAME

Charles F. J. Bulgen

(a) RESIDENCE, NO.

1109 Ridgely St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary J. Bulgen-Sing

6 DATE OF BIRTH (month, day, and year)

April 1 1878

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47211

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Inspector of Air
B & O R.R.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto
md

10 NAME OF FATHER

John H. Bulgen

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto, Md.

12 MAIDEN NAME OF MOTHER

Mary J. Bulgen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto
md

14

Informant (Address)

Mrs. Mary J. Bulgen
1109 Ridgely St.

JUN 14 1920

Port P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-12 19 20

17

I HEREBY CERTIFY, That I attended deceased from June 6, 19 20, to June 12, 19 20, that I last saw him alive on June 12, 19 20.and that death occurred, on the date stated above, at 1200 m.

The CAUSE OF DEATH* was as follows:

Pulmonary TuberculosisCONTRIBUTORY (Secondary) Strep (duration) yrs. 6 mos. ds. (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? Strep, Sputum
(Signed) Thos. J. Green M. D., 19 (Address) 1722 Holmdel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral CemJune 15 19 20

20 UNDERTAKER

ADDRESS

James Dignan & Son1005 Pac

Physician should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

D43992

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43992

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *79* *W. Cross St.*)

ST.: *W* WARD)

REGISTERED NO. C

2-FULL NAME

John Ault

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *603 W. Cross St.*)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Aug 7, 1868
(Month) (Day) (Year)

7-AGE,

51 yrs. *10* mos. *5* ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Harmon maker

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. E. Ault*

(Address) *603 W. Cross St.*

15-

Robert P. Harrison,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH,

Jan 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)

and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Valvular Heart disease

(Duration) *Don't know*

CONTRIBUTORY (Secondary)

Excision of heart

(Duration) *14 days*

(Signed) *W. H. Gorman* M. D. (Coroner.)

6-14, 1920 (Address) *117 W. Saratoga St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs.... mos.... ds. In the State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Lodge Park cemetery *Jan 15, 1920*

20-UNDERTAKER ADDRESS

James Sigmundson *1000 S. Broad St.*

Physicians should state exact statement of occupation. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

043993

HEALTH DEPARTMENT—CITY OF BALTIMORE

043993

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5-9 Brick Hill ST.; 13 WARD)

2-FULL NAME

Henry W. Murray

(a) RESIDENCE. NO.

59 Brick Hill ST.,

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Amanda E. Murray

6 DATE OF BIRTH (month, day, and year)

June 22 1845

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

74

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Mill Hand

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant

Amanda Murray

(Address)

59 Brick Hill

Filed

19

Registrar

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 13 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 20, 1920, to June 10, 1920,

that I last saw him alive on June 10, 1920,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) 0 yrs. 1 mos. + ds.

CONTRIBUTORY

(Secondary)

Pulmonary

Tuberculosis

(duration) chronic yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) H. C. Marshall, M. D.

, 19 (Address) 3311 Abell Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL OF REMAINS

DATE OF BURIAL

Popple Grove
Warren Md

June 15 1920

20 UNDERTAKER

ADDRESS

Chunoweth Son Chestnut St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D43994

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43994

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2629 Edmondson Ave. ST. 20 WARD)

2-FULL NAME Mrs. Helen E. Long

(a) RESIDENCE. No. 2629 Edmondson Ave. ST. 20 WARD.

(Usual place of abode) Length of residence in city or town where death occurred 75 yrs. 9 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Long

6 DATE OF BIRTH (month, day, and year) Aug 24, 1844

7 AGE Years 75 Months 9 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper (b) General nature of industry, business, or establishment in which employed (or employer) Hangwork (c) Name of employer S. C. Baltord

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Geo. Boul. Linde

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Wm. W. Wallace (Address) 2629 Edmondson Ave.

15 Filed JUN 15 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to June 14, 1920, that I last saw her alive on June 13, 1920, and that death occurred, on the date stated above, at 10.30 A. M. The CAUSE OF DEATH* was as follows:

Acute Pericarditis

CONTRIBUTORY (Secondary) arterio-sclerosis (duration) yrs. 7 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. A. O'Neill M. D.

(Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Westhampton Cemetery

June 16, 1920

20 UNDERTAKER

ADDRESS

Westhampton 1923 N. Lafayette Ave

D43995

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43995

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Robert Richmond Forrester

(Residence in Baltimore: No.

Hebrew Hospital

St.; yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Single

6-DATE OF BIRTH

Nov. 26, 1892
(Month) (Day) (Year)

7-AGE

27 yrs. 6 mos. 19 ds.

If LESS than 1 day,
...hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Broker

086

9-BIRTHPLACE,
(State or Country),

U. S.

10-NAME OF FATHER,

Geo W. Forrester

11-BIRTHPLACE OF FATHER
(State or Country),

Ga.

12-MAIDEN NAME OF MOTHER

Rena Richmond

13-BIRTHPLACE OF MOTHER
(State or Country),

Ga.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs W. E. Jarnagin

(Address)

57 Juniper St. Baltimore

15-

Filed

JUN 15 1920

ROBERT A. KRAUTER

101

Baltimore Health Department

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Feb. 17, 1920, to June 14, 1920,

that I saw him alive on June 14, 1920,

and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Traumatic Neuritis to filaments of

Cauda Equina

Due to Gun-shot wound in lower lumbar region

(Duration) 1 yr. 9 mos. ds.

CONTRIBUTORY..... Pyonephrosis - Duration?

(Secondary) Uremia - 6 days.

(Signed) Benj. Jacks M. D.

101... (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 3 mos. 28 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? St. Mihiel, France

Former or usual residence 2525 Peachtree Road, Atlanta, Ga.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Atlanta, Ga. June 15, 1920

20-UNDERTAKER

ADDRESS

Wm. J. Jackson, 101 North St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

D43996

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 1/2 N. Vincent ST. 19 WARD)

2-FULL NAME

Anna Clark

(a) RESIDENCE. No.

401 1/2 N. Vincent ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Samuel Clark

6 DATE OF BIRTH (month, day, and year)

1886

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Hartford Ct. Ind.

10 NAME OF FATHER

?

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Ind.

12 MAIDEN NAME OF MOTHER

?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

?

14

Informant (Address)

Add America 1623 Pierce St

15

Filed

JUN 15 1920

ROBERT E. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1920

17

I HEREBY CERTIFY, That I attended deceased from Mar 1, 1920, to June 4, 1920, that I last saw her alive on June 10, 1920, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

metastatic Carcinoma Liver & Stomach

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

Carcinoma Breast

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed)

Blair M. D.

6/14, 1920 (Address)

1707 E. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Samuel Ind.

June 16 1920

20 UNDERTAKER

ADDRESS

E & B Harbo

115 E. Wootch

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 621 Green Willow ST. 17 WARD)
2-FULL NAME Charlotte Monroe
(Residence in Baltimore: No. 621 Green Willow St.; yrs. 54 mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE Black 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow
6-DATE OF BIRTH Jan 1852
(Month) (Day) (Year)

7-AGE 68 yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laundress
(b) General nature of industry, business, or establishment in which employed (or employer). 041

9-BIRTHPLACE (State or Country) Maryland

10-NAME OF FATHER James Chester

11-BIRTHPLACE OF FATHER (State or Country) unknown

12-MAIDEN NAME OF MOTHER Anna Tubman

13-BIRTHPLACE OF MOTHER (State or Country) unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Gibson

(Address) 621 Green Willow St.

15- JUN 15 1920 ROBERT J. ELSTER

Filed 191 Barth P. P. O'Leary Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH June 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

And that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(Duration) 2 yrs. mos. ds.

(Signed) J. E. McHenry M. D.

(Coroner) June 14, 1920 (Address) 2802 Eastland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. ... yrs. ... mos. ... ds. In the State. ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, St. Paul

DATE OF BURIAL, June 15, 1920

20-UNDERTAKER James Easton

ADDRESS 916

James Easton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D43998

CERTIFICATE OF DEATH.

D43998

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST. 27 WARD)

2-FULL NAME Sarah Shaw or Sarah Bleuklin

(a) RESIDENCE. NO. 401 W. Pratt ST. _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Don't know mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Don't know

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 49 Months — Days — If LESS than 1 day, hrs. — or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Don't know

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer 087

9 BIRTHPLACE (city or town) (State or country) Don't know

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't know

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant (Address) Hospital Records Bay View Hosp.

15 Filed JUN 15 1920

ROBERT E. KROGER

Burial Permit 0106

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1920

17 I HEREBY CERTIFY, That I attended deceased from March 11 1920 to June 13 1920

that I last saw her alive on June 13 1920 and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (terminal)

(duration) yrs. mos. ds. 3
CONTRIBUTORY Senile Dementia
(Secondary) (duration) yrs. mos. ds. 5

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? NO

What text confirmed diagnosis (Signed) Crawford A. Hart M. D.
19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer June 15 1920

20 UNDERTAKER ADDRESS John G. Liebman 425 S. Lucas St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—4-9-19—H. P. Co.—1000 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

043999

CERTIFICATE OF DEATH.

28 043999

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *713 S. Decker Ave* ST.: *1* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Lewis

(a) RESIDENCE. No.

713 S. Decker Ave ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

3

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

6a If married, widowed, or divorced

(or) WIFE of

Philip Lewis

6 DATE OF BIRTH (month, day, and year)

Aug. 7, 1874

7 AGE

Years

Months

Days

If LESS than

1 day,.....hrs.

or.....min.

45 10 5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Wales.

10 NAME OF FATHER

James Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

England

12 MAIDEN NAME OF MOTHER

Elizabeth Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Wales

14

Informant (Address)

Philip Lewis 713 S. Decker Ave

15

Filed

19

ROBERT E. KRAUTER

Registrar

JUN 15 1920

Basal Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 12 1920

17

I HEREBY CERTIFY, that I attended deceased from

Oct. 11, 1919, to *June 12, 1920*,

that I last saw her alive on *11, 1920*

and that death occurred, on the date stated above, at *7 4* m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) *1* yrs. *6* mos. ds.

CONTRIBUTORY (Secondary)

Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? *At home*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis

Physical signs

(Signed) *Robert S. Weir*, M. D.

, 19 (Address) *408 Clattok Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Carmel Cem.

June 15 1920

20 UNDERTAKER

ADDRESS

J. Sander Sons

1710 North

Dr. Charles S. Neer.

408

S. Patterson Plk Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44000

CERTIFICATE OF DEATH.

64 D44000
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 St. Hamburg ST.; 21 WARD)

2-FULL NAME

(Residence in Baltimore: No. 625 St. Hamburg St.; 66 yrs., 8 mos. 13 da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
4-COLOR OR RACE. White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widowed
(Write the word.)

6-DATE OF BIRTH, Oct 1st, 1853
(Month) (Day) (Year)

7-AGE, 66 yrs., 8 mos., 13 da.
If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House Duties
(b) General nature of industry, business, or establishment in which employed (or employer). at Home

9-BIRTHPLACE, (State or Country), Baltimore Md

10-NAME OF FATHER, Joseph Treuting

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Ziegler

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August F. Stiebel

(Address) 625 St. Hamburg St.

15-

Filed JUN 15 1920

ROBERT B. KRAUTER
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 14th, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1919, to June 14, 1920, that I saw him alive on June 14, 1920, and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) Smith's debility

(Duration) ... yrs. ... mos. ... da.

(Signed) M. D.

June 14, 1920 (Address) 625 St. Hamburg St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem.

DATE OF BURIAL, June 17, 1920

20-UNDERTAKER, Mr. John W. Deufel

ADDRESS, 801 N. Fayette St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D44001

D44001

PLACE OF DEATH

CITY OF BALTIMORE (No. *Maryland Gen. Hosp* ST. *21* WARD)

FULL NAME

(Residence in Baltimore: No. *917 S. Laca*

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUN 15 1920

ROBERT F. BRAUTER Registrar

BRIEF PERMIT TO BURY

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

... find that said deceased came to death (Inquest, au-

on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44002

CERTIFICATE OF DEATH.

64 D44002
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 Argyle Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1304 Argyle Ave St.; 35 yrs., 3 mos., 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F

4-COLOR OR RACE,

C5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH,

unknown, 1 (Month) (Day) (Year)

7-AGE,

53

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION;

(a) Trade, profession, or particular kind of work. Cook
(b) General nature of industry, business, or establishment in which employed (or employer) OR

9-BIRTHPLACE, (State or Country),

md

10-NAME OF FATHER,

Henry Hawkins

11-BIRTHPLACE OF FATHER (State or Country),

md

12-MAIDEN NAME OF MOTHER

Mary Coates

13-BIRTHPLACE OF MOTHER (State or Country),

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E Emory(Address) 1304 Argyle Ave

15-

Filed

JUN 15 1920ROBERT E KEAUTEK

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 13, 1920 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 4 1920, to June 13 1920, that I saw h e alive on June 12 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
(Duration).....yrs.....mos. 14 ds.

CONTRIBUTORY (Secondary)

(Signed) H. S. M. Card M. D.
6/14, 1920 (Address) 2000 N. Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Int. Auburn

DATE OF BURIAL,

June 13, 1920

20-UNDERTAKER

W. H. Holland

ADDRESS

1631 N. Hill

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D44001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Foster(a) RESIDENCE. No. 1641 St. Joseph's

(Usual place of abode)

ST. 8 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored5 Single, Married, Widowed,
or Divorced (write the word)Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofFlorence Foster6 DATE OF BIRTH (month, day, and year) Unknown 897

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.23

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workLabourer(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

Chas Foster

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

Florence Foster
1641 St Joseph St

15

JUN 15 1920ROBERT E. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 13 1920

17

I HEREBY CERTIFY, That I attended deceased from
June 11 1920 to June 13 1920that I last saw him dead June 13 1920and that death occurred, on the date stated above, at 11:15 PThe CAUSE OF DEATH was as follows:
pulmonary oedema

(duration) yrs. mos. ds.

EpilepsyCONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

Unknown

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical signs

(Signed)

J. B. Bronushas

M. D.

14, 150 (Address) St. Joseph's hospital*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Farmerville VaJune 17 1920

20 UNDERTAKER

ADDRESS 1725Mrs Robt A Elliott Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Hks.

D44005

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D44005

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1430 E. Monument ST.; 10 WARD)

2-FULL NAME

Mary L. Grimes

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

1430 E. Monument

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (write the word)

Widow

6a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

John Grimes

6 DATE OF BIRTH (month, day, and year)

1884-June 8-

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

36

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housemaid 170

(b) General nature of industry, business, or establishment in which employed (or employer)

Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant (Address)

Mr. Richardson
1430 E. Monument

15

Filed

19

JUN 15 1920

ROBERT K. REAGAN

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 12 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 25, 1920, to June 12, 1920,

that I last saw her alive on June 12, 1920,

and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Septicemia as result
of operation at St. Joseph's
Hospital for Uterine Fibroma

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

Operation for Uterine
Fibroma (duration) yrs. mos. 30 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of April 1920

Was there an autopsy? Yes

What test confirmed diagnosis?

Hist. & Symptoms by

(Signed) W. C. Burns, M. D.

(Address) 2218 E. Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laural Cemetery

June 15 1920

20 UNDERTAKER

Mrs. R. A. Elliott

ADDRESS

1725-
Ashland
Ae

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

144006

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 144006

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2507 Christian ST. 20 WARD)

2-FULL NAME

Margaret Frederick

(a) RESIDENCE. No. 2507 Christian ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18-1902

7 AGE Years 17 Months 10 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City (State or country)

10 NAME OF FATHER John Frederick

11 BIRTHPLACE OF FATHER (city or town) Balto City (State or country)

12 MAIDEN NAME OF MOTHER Lillie Strong

13 BIRTHPLACE OF MOTHER (city or town) Balto City (State or country)

14 Informant John Frederick (Address) 2507 Christian St

15 Filed JUN 15 1920 ROBERT F. KAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1920

17 I HEREBY CERTIFY, That I attended deceased from May 24 1920, to June 13 1920, that I last saw her alive on June 12 1920, and that death occurred, on the date stated above, at 5 P m. The CAUSE OF DEATH* was as follows:

Chron. Endocarditis
Mitral murmur
about (duration) 4 yrs. mos. ds.
CONTRIBUTORY Secondary anaemia
(Secondary) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? 710
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? E. Conner
(Signed) Chas. E. Conner M. D.
6/14, 1920 Address) 1101 N. Fulton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (Use reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

Geo. L. Schmat 7130 2101 Luth

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44007

CERTIFICATE OF DEATH.

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1703 N. Mount St. 15 WARD)

2-FULL NAME Baby Golden

(Residence in Baltimore: No. 1703 N. Mount St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, June 12, 1920

7-AGE, 2 yrs. 1 mos. 1 ds.

If LESS than 1 day, 2 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, none
(b) General nature of industry, business, or establishment in which employed (or employer), none

9-BIRTHPLACE, (State or Country), Balt. Md.

10-NAME OF FATHER, Robert Ridgely

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Bertha Golden

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Bertha Golden

(Address), 1703 N. Mount St.

15-JUN 15 1920

Filed 191

ROBERT H. KRAUTER

Deputy Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 12, 1920

(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Infant formula water

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hammerly M. D.

(Coroner.) June 13, 1920 (Address) 2802 Edgemoor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Peter's Church

DATE OF BURIAL, June 15 1920

20-UNDERTAKER

JAMES H. DENNIS

1303 PRESTMAN ST.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44008

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *5118 Wayne Ave.* ST. *28* WARD)

2-FULL NAME *William Alexander McClymont*

(a) RESIDENCE. No. *5118 Wayne Ave.* ST. *28* WARD. *(Resident)*
(Usual place of abode)

Length of residence in city or town where death occurred *58* yrs. *5* mos. *23* ds. How long in U. S., if of foreign birth? *58* yrs. *5* mos. *23* ds.

REGISTERED NO. *D44008*
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mary A. McClymont*

6 DATE OF BIRTH (month, day, and year) *Dec. 21-1861*

7 AGE Years *58* Months *5* Days *23* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *(Clerk) Retired*

(b) General nature of industry, business, or establishment in which employed (or employer) *from U.S. Census*

(c) Name of employer *Benson, Washington D.C.*

9 BIRTHPLACE (city or town) *Baltimore*
(State or country) *Maryland*

10 NAME OF FATHER *Alex. McClymont*
11 BIRTHPLACE OF FATHER (city or town) *Baltimore*
(State or country) *Maryland*

12 MAIDEN NAME OF MOTHER *Susan Johnson*

13 BIRTHPLACE OF MOTHER (city or town) *Scotland*
(State or country)

14 Informant *Mrs Mary A. McClymont (wife)*
(Address) *5118 Wayne Ave*

15 *JUN 15 1920*

ROBERT E. REGISTER
Registrar

Death Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *6-13-1920*

17 I HEREBY CERTIFY, That I attended deceased from *Sept. 1, 1918* to *June 13, 1920*, that I last saw him alive on *June 13, 1920*, and that death occurred, on the date stated above, at *7* o'clock m. The CAUSE OF DEATH* was as follows:

Chronic & Intermittent Nephritis

(duration) *2* yrs. *5* mos. *23* ds.
CONTRIBUTORY (Secondary) *Arterio Sclerosis*
(duration) *2* yrs. *5* mos. *23* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?
(Signed) *Shepherd D. Dand*, M. D.
, 19 (Address) *1227 Glenview*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Gravillmont Cemetery *June 15/1920*
20 UNDERTAKER ADDRESS

STEWART & MOWEN COMPANY
(WILLIAM E. MOWEN, Successor)

108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44009

120 D44009

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *MT Hope Retnat* ST.: *28* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Miller -

(a) RESIDENCE. No. *Baltimore Md -*

(Usual place of abode)

ST., *---* WARD. *---*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *4* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *---* yrs. *---* mos. *---* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married -*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Wife of Mr Miller -*

6 DATE OF BIRTH (month, day, and year) *Feb 4 - 1865*

7 AGE *55* Years *0* Months *0* Days If LESS than 1 day, *---* hrs. or *---* min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer) *---*

(c) Name of employer *---*

9 BIRTHPLACE (city or town) *Baltimore Md* (State or country)

10 NAME OF FATHER *Patrick Leonard*

11 BIRTHPLACE OF FATHER (city or town) *Not given* (State or country) *Ireland*

12 MAIDEN NAME OF MOTHER *Annie Birmingham*

13 BIRTHPLACE OF MOTHER (city or town) *Not given* (State or country) *Ireland*

14 Informant *Records of Mt Hope Retnat* (Address) *not stated*

15 Filed *JUN 15 1920* *ROBERT A. LEVITT* Registrar *Boston*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 13* 19*20*

17 I HEREBY CERTIFY, That I attended deceased from *Jan*, 19*14*, to *June 13*, 19*20*, that I last saw him alive on *June 13*, 19*20*, and that death occurred, on the date stated above, at *9.40* p. m. The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis - Complicated by the Cardiac Dilatation

CONTRIBUTORY *Chr. Melancholia -* (Secondary) (duration) *4* yrs. *0* mos. *0* ds.

18 Where was disease contracted *Baltimore Md* if not at place of death?

Did an operation precede death? *No* Date of *---*

Was there an autopsy? *---*

What test confirmed diagnosis? (Signed) *Frank J. Flannery* M. D. , 19 (Address) *Mt Hope Retnat*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Holy Cross Cemetery* DATE OF BURIAL *June 16* 19*20*

20 UNDERTAKER *STEWART & MOWEN COMPANY* ADDRESS *108 W. NORTH AVE.* (WILLIAM F. WOODEN, Successor)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Riviera Aprt., ST.: 13 WARD)

2-FULL NAME Louis J. Butzel,

(a) RESIDENCE. No. Lake Drive & Linden Ave., ST. New York, WARD. New York
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. 9 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 24th. 1846

7 AGE Years 73 Months 7 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Retired,

(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods,

(c) Name of employer

9 BIRTHPLACE (city or town) Kiskton, (State or country) N.Y.

10 NAME OF FATHER John L. Butzel,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany,

12 MAIDEN NAME OF MOTHER Elizabeth Herman,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany,

14 Informant Mrs. J. Butzel, (Address) Riviera, Apts.

15 ROBERT E. KRAUTER Registrar
JUN 15 1920 Social Permit Office

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1920

17 I HEREBY CERTIFY. That I attended deceased from June 14, 1920, to June 14, 1920, that I last saw him alive on June 14, 1920, and that death occurred, on the date stated above, at 10:00 P. m. The CAUSE OF DEATH* was as follows:

arteriosclerosis - hypertensio - & diabetes
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of lungs.
(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Lutz, M. D.

6/14, 1920 (Address) 2040 Canton Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn N.Y. Cypress Hills DATE OF BURIAL June 16th 20

20 UNDERTAKER Howard Southerin ADDRESS 118th St. N.Y.C.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44011

CERTIFICATE OF DEATH.

64 D44011

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 631 W. Saratoga ST.; 4 WARD)

2-FULL NAME

(Residence in Baltimore: No. 631 W. Saratoga St. St.; 62 yrs., 6 mos., 6 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Single

6-DATE OF BIRTH,

..... Dec 6 1857
(Month) (Day) (Year)

7-AGE,

..... 62 yrs. 6 mos. 6 ds.If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....Housework
at home9-BIRTHPLACE,
(State or Country),Baltimore

PARENTS.

10-NAME OF
FATHER,Henry Fitzberger11-BIRTHPLACE
OF FATHER
(State or Country),Germany12-MAIDEN NAME
OF MOTHERMathematic Schickner13-BIRTHPLACE
OF MOTHER
(State or Country),Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. B. Bauman(Address) 631 W. Saratoga

15-

Filed.....

JUN 15 1920

Baltimore

Baltimore

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

..... June 13 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 8th 1920, to June 13th 1920,that I saw her alive on June 12th 1920,and that death occurred, on the date stated above, at 29 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis..... (Duration) 2 yrs. 1 mos. 1 ds.CONTRIBUTORY
(Secondary)..... (Duration) 1 yrs. 1 mos. 1 ds.(Signed) William F. Stielman M. D......, 101... (Address) 1227 W. May St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cemetery

DATE OF BURIAL,

June 15 1920

20-UNDERTAKER

W. M. Roulton

ADDRESS

2238 N. North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44012

CERTIFICATE OF DEATH.

28 ✓ D44012

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Dobson

(a) RESIDENCE. NO. 512 Montgomery St. ST. Unknown WARD. Unknown

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE Years 25 Months 08 Days 26 If LESS than 1 day, hrs. 00 or min. 00

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory work

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Washington, D. C.

10 NAME OF FATHER James Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington, D. C.

12 MAIDEN NAME OF MOTHER Mason Dobson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington, D. C.

14 Informant Hospital Records (Address) M. T. H.

15 Filed JUN 15 1920 ROBERT R. KRAUTER Registrar

Barial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1920

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1920, to June 11, 1920.

that I last saw her alive on June 11, 1920.

and that death occurred, on the date stated above, at 5.55 p. m.

The CAUSE OF DEATH* was as follows:

Primary Tuberculosis

(duration) yrs. 10 mos. 00 ds.

CONTRIBUTORY (Secondary)

Chronic nephritis (duration) yrs. 2 mos. 00 ds.

18 Where was disease contracted If not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum.

(Signed) George W. Wilkerson M. D.

6-12-20 Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn

6-15 1920

20 UNDERTAKER

John H. Trachin 142

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44013

CERTIFICATE OF DEATH.

110 D44013
REGISTERED NO. C

1-PLACE OF DEATH

Church Home and Infirmary

CITY OF BALTIMORE: (No.

North Broadway

ST.;

WARD)

2-FULL NAME

Mrs. Anna Burns

(Residence in Baltimore: No.

2509 Jefferson St.

St.;

yrs.,

mos.

ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH,

Nov.

17th

1880

(Month)

(Day)

(Year)

7-AGE,

39

6

27

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Baltimore City

10-NAME OF FATHER,

Nicholas Vertel

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Elizabeth Vertel

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Nicholas Burns

(Address)

2509 E. Jefferson St.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June

13

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 11 1920, to June 13 1920,

that I saw her alive on

June 13 1920,

and that death occurred, on the date stated above, at 11:45 P.m.

The CAUSE OF DEATH* was as follows:

Intestinal Adhesions with
Partial Obstruction

(Duration).....yrs....3....mos....2....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs....mos....ds.

(Signed).....Walter T. Anderson, M. D.

June 13, 1920 (Address) Church Home and Inf.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 3 mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 2509 Jefferson St.

Former or usual residence 2509 Jefferson St.

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

DATE OF BURIAL,

JUN 17 1920

20-UNDERTAKER

Geo. M. Fink & Son,

ADDRESS

811 N Wolfe

Funeral Directors & Embalmers.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 15 1920

ROBERT A. KAUTER

Filed.....

191.

Baltimore City Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44014

CERTIFICATE OF DEATH.

79 ✓
D44014
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2208 Greenmount Ave. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

2208 Greenmount Ave.

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE

MARRIED

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Feb 22, 1869
(Month) (Day) (Year)

7-AGE,

51 yrs. 3 mos. 23 ds.

10-LESS than 1 day.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Saloman 666

9-BIRTHPLACE,
(State or Country),

Balt.

10-NAME OF FATHER,

Geo. Schmitt

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Annie M. Seigrist

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Geo. A. Schmitt

(Address) 2208 Greenmount Ave.

15-

Filed JUN 15 1920

ROBERT A. KAUTER

Burial Permitted

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 14th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 17th, 1912, to June 14th, 1920, that I saw him alive at 3 p. m. June 14th, 1920, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Heart Disease with dilation
of left ventricle; Cardiac insufficiency;
with anemia; Acute Pleural Effusion.

(Duration) 30 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Coronary Atherosclerosis

(Signed) Wilmer Brinton M. D.

June 15th, 1920 (Address) 111 W. Co. Street, Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Cross

DATE OF BURIAL,

June 16 1920

20-UNDERTAKER

C. A. Wiedefeld, Green Mt. Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44015

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44015

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph Hosp 26* WARD)

2-FULL NAME *Mrs. E. Hutchinson*

(a) RESIDENCE. No. *823 S. Bouldin* ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *19* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *7* 4 COLOR OR RACE *W.* 5 Single, Married, Widowed, or Divorced (write the word) *m.*

5a If married, widowed, or divorced
HUSBAND of *Geo. W. Hutchinson*
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan 11 1901*

7 AGE Years *19* Months *5* Days *2* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House work*

(b) General nature of industry, business, or establishment in which employed (or employer) *037*

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Md.*
(State or country)

10 NAME OF FATHER *Michael J. Murphy*

11 BIRTHPLACE OF FATHER (city or town) *Balto. Co. Md.*
(State or country)

12 MAIDEN NAME OF MOTHER *Katherine J. Spangler*

13 BIRTHPLACE OF MOTHER (city or town) *Balto. Co. Md.*
(State or country)

14 Informant *Michael J. Murphy*
(Address) *823 S. Bouldin St.*

15 Filed *Robert P. Harrison* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 13 1920*

17 I HEREBY CERTIFY, That I attended deceased from *June 10*, 19 *20*, to *June 13*, 19 *20*, that I last saw him alive on *June 13th*, 19 *20*, and that death occurred, on the date stated above, at *7:15 P. M.*
The CAUSE OF DEATH* was as follows:

Myocardial Infarct.

(duration) yrs. mos. *3* ds.

CONTRIBUTORY *Melanotic Sarcoma of Intestines*
(Secondary) (duration) yrs. *3* mos. ds.

18 Where was disease contracted *2*
if not at place of death?

Did an operation precede death? *yes* Date of *June 10, 1920*

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Frank C. Marino*, M. D.

4 19 (Address) *St. Joseph Hosp*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Carmel Cemetery *June 17 1920*

20 UNDERTAKER ADDRESS

Gukler + Gukler *1729 E. Eager*

Burial Permit Clerk

D44016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44016

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1911 Orleans ST.; 6 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 1911 Orleans ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Keller6 DATE OF BIRTH (month, day, and year) Dec 25, 18527 AGE Years 67 Months 5 Days 21 If LESS than 1 day, hrs. or min.8 OCCUPATION OF DECEASED Cooper

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)10 NAME OF FATHER Jacob Keller11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)12 MAIDEN NAME OF MOTHER Jane Gider13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)14 Informant Barbara Keller (Address) 1911 Orleans15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 192017 I HEREBY CERTIFY, That I attended deceased from May 2nd, 1920, to June 15, 1920, that I last saw him alive on June 14th, 1920, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Central hemorrhageCONTRIBUTORY (Secondary) Cardiac hypertrophy, bilateral nephritis (duration) yrs. mos. ds. 218 Where was disease contracted at home If not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical(Signed) J. T. Rues, M. D.June 15, 1920 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore DATE OF BURIAL June 18, 192020 UNDERTAKER Girkler & Girkler ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every fact of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 15 1920

Burial Permit Class

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44012

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

2-FULL NAME Baby Elkins

(a) RESIDENCE. No. 844 Eutaw ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12th 1920

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER Percy Elkins

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Leona Burke

13 BIRTHPLACE OF MOTHER (city or town) N York City (State or country)

14 Informant Hospital Records (Address) University Hospital

15 Filed Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-12-20

17 I HEREBY CERTIFY, That I attended deceased from June 12th 1920 to June 12th 1920, that I last saw her alive on June 12th 1920, and that death occurred, on the date stated above, at 2nd a.m.

The CAUSE OF DEATH* was as follows:

Asphyxia neonatorum

(duration) yrs. mos. ds.
CONTRIBUTORY Toxemia of mother
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings
(Signed) J. A. Buchness M. D.
, 19 University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL* DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

ADDRESS

JUN 15 1920

Burial Permit

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

buried by city-
D44018 HEALTH DEPARTMENT—CITY OF BALTIMORE D44018
28
PLACE OF DEATH
CITY OF BALTIMORE (No. *613 Cedar ally* ST. *4* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Edmund Proctor*
(Residence in Baltimore: No. *613 Cedar ally* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.
3-SEX, *Male* 4-COLOR OR RACE, *Black* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)
6-DATE OF BIRTH, *Don't know*, 1 (Month) (Day) (Year)
7-AGE, *48 about* If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Don't know*
(b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country), *Don't know*
PARENTS.
10-NAME OF FATHER, *1 1*
11-BIRTHPLACE OF FATHER (State or Country), *1 1*
12-MAIDEN NAME OF MOTHER, *1 1*
13-BIRTHPLACE OF MOTHER (State or Country), *1 1*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant).....
(Address).....

15- Robert P. *Barrios* Johns Hopkins Hospital
JUN 15 1920
Burial Permit *101* Registrar.

CORONER'S CERTIFICATE OF DEATH.
16-DATE OF DEATH, *Jan 11*, 19*20* (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) *Don't know* (Duration) yrs. mos. ds.
(Signed) *N. K. Gonsalves* M. D. (Coroner.)
6-14, 19*20* (Address) *117 N. Saratoga*
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....
19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 19....
20-UNDERTAKER *Johns Hopkins Hospital* ADDRESS *Johns Hopkins Hospital*

Missing
#D 44019

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44020

D44020

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *137 N. Chapel.* ST.: *5* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Catharine Jubb(a) RESIDENCE. NO. *137 N. Chapel.* ST. WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* mos.

ds.

How long in U. S., if of foreign birth? yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Widow</i>
------------------------	---------------------------------	--

5a If married, widowed, or divorced *Widow*
HUSBAND of *Jesse Jubb.*
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *March 7 - 1893*

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<i>27</i>	<i>3</i>	<i>11</i>	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*
(State or country) *md.*10 NAME OF FATHER *Christian Winterling*11 BIRTHPLACE OF FATHER (city or town) *Germany*
(State or country)12 MAIDEN NAME OF MOTHER *Mary E. Stenger*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore*
(State or country) *md.*14 Informant *Leo. Winterling*
(Address) *Middle River.*15 Filed *Robert P. Harrison,*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 13* 19 *20*

17 I HEREBY CERTIFY, That I attended deceased from *May-26-*, 19*20*, to *June 13-*, 19*20*, that I last saw her alive on *June - 12 -*, 19*20*, and that death occurred, on the date stated above, at *8.30 A.* m. The CAUSE OF DEATH* was as follows:

Intestinal Tuberculosis(duration) *9* yrs. *9* mos. *7* ds.

CONTRIBUTORY (Secondary)

Interstitial Nephritis(duration) *—* yrs. *—* mos. *20* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *William H. Johnson*, M. D.4/4, 1920 (Address) *3016 Guilford ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Ch**June 16* 19 *20*

20 UNDERTAKER

ADDRESS

*Lilly W. Fisher**403 S. Wolfe*

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH CARE. Information should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

JUN 15 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44021

D44021

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph Hosp.* ST.; *1* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Elyah Reagan*(a) RESIDENCE. NO. *701 S. Calumet* ST.; *1* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *46* yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

*M.*5a If married, widowed, or divorced (or) WIFE of *John J. Reagan*6 DATE OF BIRTH (month, day, and year) *1874*

7 AGE

Years

Months

Days

If LESS than 1 day, — hrs. or — min.

46

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *H. W.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Md.*
(State or country)10 NAME OF FATHER *Alex. Duncan*11 BIRTHPLACE OF FATHER (city or town) *Md.*
(State or country)12 MAIDEN NAME OF MOTHER *Mary A. Bogue*13 BIRTHPLACE OF MOTHER (city or town) *Md.*
(State or country)14 Informant (Address) *John J. Reagan*
701 S. Calumet St.

15

JUN 15 1920

Robert F. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 13th* 19*20*17 I HEREBY CERTIFY, That I attended deceased from *June 2*, 19*20*, to *June 13*, 19*20*, that I last saw him alive on *June 13*, 19*20*, and that death occurred, on the date stated above, at *4 a. m.*
The CAUSE OF DEATH* was as follows:*Myocardial Insufficiency*CONTRIBUTORY (Secondary) *Acute Cholelithiasis*
(duration) — yrs. — mos. — ds. *3* ds.18 Where was disease contracted if not at place of death? *2*Did an operation precede death? *yes*. Date of *June 9, 20*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Frank C. Mamm*19, 19*20* (Address) *St. Joseph Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery June 16 19*20*

20 UNDERTAKER

Lilly & Zeller

ADDRESS

403 S. Wolfe St.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Megacolon*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

For Removal of Gall Bladder

D44022

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D44022

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2219 Canary Court ST. 1 WARD)

2-FULL NAME

Martin Haas.

(a) RESIDENCE. NO.

2219 Canary Court ST. 1 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds.

(If nonresident give city or town and State)

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of

Anna Haas.

6 DATE OF BIRTH (month, day, and year)

1873

7 AGE

47

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Martin Haas.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Caroline Krug.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Anna Haas.
2219 Canary Court.
Robert F. Harrison,

Registrar

16 DATE OF DEATH (month, day, and year)

June 13 1920

17

I HEREBY CERTIFY. That I attended deceased from

May 22 1920 to June 13 1920

that I last saw him live on June 11 1920

and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical signs

What test confirmed diagnosis? Les. Helber M. D.

(Signed) 6-14-20 Address 1937 Zough St

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mount Carmel Cem

DATE OF BURIAL

June 16 1920

20 UNDERTAKER

Lilly & Ziller

ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH CAPITALS, WITH CARE. AGE should be carefully supplied. AGE should be properly classified. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

JUN 15 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *New City Hosp.* ST. *26* WARD)

2-FULL NAME

Reba Kaine

(a) RESIDENCE, NO.

*408 Highland*ST. *26* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

38 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Fred Kaine*

6 DATE OF BIRTH (month, day, and year)

1897

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*23*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Pennsylvania*

10 NAME OF FATHER

(?) Brush

11 BIRTHPLACE OF FATHER (city or town)

(?)

(State or country)

12 MAIDEN NAME OF MOTHER

Mae (?)

13 BIRTHPLACE OF MOTHER (city or town)

(?)

(State or country)

14

Informant
(Address)*Hospital Records
New City Hosp.*

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *6-12 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*6-10 1920 to 6-12 1920*that I last saw her alive on *6-12 1920*and that death occurred, on the date stated above, at *2:50 P.M.*

The CAUSE OF DEATH* was as follows:

*General Septicæmia**unknown* (duration) yrs. mos. ds.CONTRIBUTORY *Broncho-Pneumonia*
(Secondary)(duration) yrs. mos. ds. *2*18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *No special test*(Signed) *J. P. Pessal* M. D.*6-12, 1920* Address) *Bay View Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Balto. Cemetery**June 16 1920*

20 UNDERTAKER

Lilly & Zuleh

ADDRESS

408 S. Wolfe St.

N. B.—WRITE PLAINLY, with information should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

JUN 15 1920

~~Journal Permit Clerk~~

D44025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44025

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *405 S. Clinton*)ST.: *26* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Henry Jacob Kroll

(a) RESIDENCE. NO.

405 S. Clinton

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Henry Kroll

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Margaret Seidelbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

*Henry Kroll
405 S. Clinton St.*

15

Filed

Robert P. Harrison,

Registrar

JUN 15 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 15* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from *June 15*, 19*20*, to *June 15*, 19*20*, that I last saw him alive on *June 15*, 19*20*, and that death occurred, on the date stated above, at *8 A.* m.

The CAUSE OF DEATH* was as follows:

*Irregular birth - premature
dyspnea congest.*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Joseph L. Valentine, M. D.*
(Address) *16 S. Broadway*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Schwartz's Cemetery**June 16* 19*20*

20 UNDERTAKER

Gibbs & Gibbs

ADDRESS

1739 E. Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK. Exact statement should be stated. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

144026

15

REGISTERED NO

ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(A) RESIDENCE. NO. 405 So Clinton

(a) RESIDENCE. NO. 405 So Clinton ST., 1 WARD. 1
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 19 20

17 I HEREBY CERTIFY, That I attended deceased from
June 15, 1920, to June 25, 1920,
that I last saw him alive on June 25, 1920,
and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

*Tetral - birth - premature
excessive weight*

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?.....

What test confirmed diagnosis? _____
(Signed) Joseph L. Valentini, M.D.

*State the Disease Causing Death, or in deaths from Violent Causes,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
--	----------------

20 UNDERTAKER	ADDRESS
Gurken + Gurken	1739 E. Cagay

JUN 15 1920 Burial Permit Clerk.

D44027

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44027

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 N. Steeple ST.: 7 WARD)2-FULL NAME John Rangan(R) RESIDENCE. NO. 720 N. Steeple ST.: 7 WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Carrie6 DATE OF BIRTH (month, day, and year) Oct 18907 AGE Years 30 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brass Moulder(b) General nature of industry, business, or establishment in which employed (or employer) Belt Foundry(c) Name of employer McShane9 BIRTHPLACE (city or town) (State or country) Balt.10 NAME OF FATHER John Rangan11 BIRTHPLACE OF FATHER (city or town) (State or country) Prhema12 MAIDEN NAME OF MOTHER Carrie13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prhema

14

Informant Carrie Rangan
(Address) Robert P. Harrison,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 192017 I HEREBY CERTIFY, That I attended deceased from Jan 3 1920 to June 14 1920that I last saw him alive on June 14 1920and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary TuberculosisCONTRIBUTORY (Secondary) Acute Edema Lungs
(duration) yrs. 6 mos. ds.18 Where was disease contracted if not at place of death? unknownDid an operation precede death? No Date of -Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred. Ruzicka M. D.15-19 (Address) 8100 N. Patterson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer June 17 1920

20 UNDERTAKER ADDRESS

Frank Cracksen 1906 Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated exactly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

JUN 15 1920 Burial Permit Clerk Registrar

D44028

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44028

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8314. Madiera ST. 7 WARD)2-FULL NAME Frank Klina(a) RESIDENCE. NO. 831 A Madiera ST. 7 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth life yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced (write the word) Married6a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Klina6 DATE OF BIRTH (month, day, and year) Mar 1885

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 35

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 1886

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Barnes & Beyer9 BIRTHPLACE (city or town) (State or country) Beth10 NAME OF FATHER Charles Klina11 BIRTHPLACE OF FATHER (city or town) (State or country) Prussia12 MAIDEN NAME OF MOTHER Sophie Klina13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prussia

14

Informant (Address) Sophie Klina
Robert P. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1920

17

I HEREBY CERTIFY (That I attended deceased from April 1, 1920, to June 14, 1920, that I last saw him alive on June 14, 1920, and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary)

(duration)

3 yrs. 2 mos. 3 ds.

(duration)

3 yrs. 3 mos. 3 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) W. J. Ryan
6/15/20(Address) 801 N. Carroll St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy RedeemerDATE OF BURIAL June 1720 UNDERTAKER Frank BrackleyADDRESS 1906 A

N. B.—WRITE PLAINLY, WITH UNFADING INK. Information should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

JUN 15 1920

Burial Permit 1006 Registrar

1044029
Spec.—6-9-19—H. P. Co.—1000 Bks.

Wanzenzsky
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 Aisquith Street ST.: 5 WARD)

2-FULL NAME Lescheblor Danzenzsky

(a) RESIDENCE. NO. 411 Aisquith Street ST.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S. If of foreign birth? 30 yrs. mos. ds.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Lich Danzenzsky

6 DATE OF BIRTH (month, day, and year) Unknown 1858

7 AGE Years 62 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Joseph Bear

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1411 E. Balto

15 JUN 16 1920 ROBERT B. KLAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1920, to Jan 15, 1920, that I last saw her alive on Jan 14, 1920, and that death occurred, on the date stated above, at 7:30 AM

The CAUSE OF DEATH* was as follows:

Mitral & Aortic insufficiency.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Occlusion & Pulmonary Constriction (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Bloke M. D.

, 19 (Address) 201 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Hehren Mt Carmel 6/16 1920

20 UNDERTAKER ADDRESS

Jack Lewis 1411 E. Balto

tion should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44030

CERTIFICATE OF DEATH.

50 D44030

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *True Hope*)ST.: *15* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *34 50 Cottage Ave.*

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *32* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Gen. Ida Jacobs*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*65*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Poland*

10 NAME OF FATHER

Isid Jacobs

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Poland

12 MAIDEN NAME OF MOTHER

Isid Jacobs

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland

14

Informant
(Address)*J. Lewis
1411 5th Ave*

15

Filed *JUN 16 1920**ROBERT A. MASTER**Barial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 15 1920

17

I HEREBY CERTIFY, That I attended deceased from

5/27, 19*20*, to *6/15*, 19*20*,that I last saw him alive on *6/15*, 19*20*,and that death occurred, on the date stated above, at *1.30* p. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus(duration) *1* yrs. *1* mos. *1* ds.CONTRIBUTORY
(Secondary)*Diabetic Gangrene of Foot*(duration) *1* yrs. *1* mos. *1* ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of *6/9*

Was there an autopsy?

Yes *Imp. of Foot*

What test confirmed diagnosis?

(Signed)

Isid Jacobs M. D.

6/15, 1920 (Address)

True Hope

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Hehren Rose Dale**6/16 1920*

20 UNDERTAKER

ADDRESS

*Jack Lewis**1411 5th Ave*

Information should be carefully supplied. This should be in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D44031

CERTIFICATE OF DEATH.

D44031

1-PLACE OF DEATH *Hebrew Hosp. tal* REGISTERED NO. C *91*
 CITY OF BALTIMORE: (No. *6* ST.: *6* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 2-FULL NAME *Sam Fradin*
 (Residence in Baltimore: No. *410 N. Wolfe St.* St.: *7* yrs., *—* mos., *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*
 6-DATE OF BIRTH, 1
 (Month) (Day) (Year)
 7-AGE, *59* yrs. mos. ds. If LESS than 1 day, hrs. or min.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. *Selton*
 (b) General nature of industry, business, or establishment in which employed (or employer). *086*

9-BIRTHPLACE, (State or Country), *Russia*
 10-NAME OF FATHER, *Sam. Fradin*
 11-BIRTHPLACE OF FATHER (State or Country), *Russia*
 12-MAIDEN NAME OF MOTHER *Unknown*
 13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Hyman Fradin*
 (Address) *410 N. Wolfe St.*

15- *JUN 16 1920* *ROBERT A. KRAUTER*
 Filed *191*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 15, 1920.*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 14, 1920*, to *June 15 1920*, that I saw him alive on *June 15 1920*, and that death occurred, on the date stated above, at *7:25 P.m.*

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

 (Duration) yrs. mos. ds.

CONTRIBUTORY *Dilated Heart*
 (Secondary)

(Signed) *Benji. Sacks* M. D.
June 15, 1920 (Address) *Hebrew Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? *+*

Former or usual residence *410 N. Wolfe St.*

19-PLACE OF BURIAL OR REMOVAL, *Hebrew Hospital* DATE OF BURIAL, *June 16, 1920*20-UNDERTAKER *Joe Lumsden* ADDRESS *427 E. Balto St.*

N. B.—Every item of information furnished is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44032

CERTIFICATE OF DEATH.

40 D44032

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 Mc Elderry St

ST. 5 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Harris Sears

(a) RESIDENCE. No. 1114 Mc Elderry St

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

27 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

27 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

married

6 DATE OF BIRTH (month, day, and year)

June 15, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Hyman Sears

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Annie Slodsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

L. Sears 1114 Mc Elderry St

15

Filed

JUN 16 1920

ROBERT A. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 15, 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 1920, to June 15, 1920.

that I last saw him alive on June 14, 1920.

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Weakened heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5 Monday

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. J. Deane, M. D.

19 (Address) 2328 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Kebur Rosedale

June 16, 1920

20 UNDERTAKER

Sol Friedman

ADDRESS 127

E. Belto St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *1th* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ida Thomas.

(a) RESIDENCE. NO.

925 Bimney St

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female**Colored**married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 20 - 1878

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*42**1**18*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress.

(b) General nature of industry, business, or establishment in which employed (or employer)

041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Samuel Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Emma Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

J. H. H. Records

15

Filed

JUN 16 1920

ROBERT E. KAUFER

Registrar

Baltimore City Health Department

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 12 1920

17

I HEREBY CERTIFY, That I attended deceased from

*June 9 - 1920, to June 12, 1920,*that I last saw him alive on *June 12, 1920,*and that death occurred, on the date stated above, at *5:20 P. M.*

The CAUSE OF DEATH* was as follows:

*Carcinoma Ovary, left.**Duration uncertain*(duration) - yrs. *3* mos. - ds. *?*

CONTRIBUTORY (Secondary)

Surgical Shock(duration) - yrs. - mos. *1/6* ds.

18 Where was disease contracted if not at place of death?

Baltimore

Did an operation precede death?

Yes Date of 6/12/20.

Was there an autopsy?

Yes.

What test confirmed diagnosis?

Yes -

(Signed)

Laurence Buchanan, M. D.

, 19

(Address)

Johns Hopkins Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Graveyard**6/16/20*

20 UNDERTAKER

Thos. White 113 1st W. York

D44034

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44034

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Hebrew Hospital* ST. *167* WARD)

2-FULL NAME

(Residence in Baltimore No. *304 S. Wolf*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *167* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) *Single*

6-DATE OF BIRTH

June 1, 1900
(Month) (Day) (Year)

7-AGE

*20*yrs. mos. *X3*If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Auto Driver

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER

Michael Bartkowski

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Mary Holcog

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Bartkowski

(Address)

304 S. Wolf St.

15-

JUN 16 1920

ROBERT F. KRAUTER

Burial permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 14, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy, or inquiry.)

thereof, and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) And that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns from failure water from radiator of Auto

CONTRIBUTORY (Secondary)

(Signed) *J. K. S. S. S.* M. D.6-10, 1920 (Address) *4 E. S. S.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death...yrs...mos...ds. State...yrs...mos...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

Holy Rosary
Funeral Home
Bartkowski

DATE OF BURIAL

6/17, 1920

ADDRESS

1618 Eastern Ave

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

D44035

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

405 S. Ann

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Josephine Stella Binkowska

(Residence in Baltimore: No.

405 S. Ann

St.:

3 yrs., 15 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH.

March 1, 1920

(Month)

(Day)

(Year)

7-AGE.

3 yrs., 15 mos. 15 ds.

If LESS than 1 day.

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE.
(State or Country).

Baltimore

10-NAME OF FATHER.

John Binkowski

11-BIRTHPLACE OF FATHER
(State or Country).

Poland

12-MAIDEN NAME OF MOTHER

Julia Goluchowska

13-BIRTHPLACE OF MOTHER
(State or Country).

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Binkowski

(Address)

405 S. Ann

15-

JUN 16 1920

STREET 1 KRAUTER

FILE

101

BALTIMORE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 14, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 12, 1920, to June 14, 1920,

that I saw him alive on June 14, 1920,

and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Pneumo - Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

June 14, 1920 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Rosary Cem.

June 16, 1920

20-UNDERTAKER

ADDRESS

James J. Binkowski

N.B.-Every item of information CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44036

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2444 Druid Hill Ave.

ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Jane Gallagher

(Residence in Baltimore: No. 2444 Druid Hill Ave.

St.; 40 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

widow

6-DATE OF BIRTH,

....., 1839

(Month)

(Day)

(Year)

7-AGE,

81

yrs., mos., ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE,
(State or Country).

Frederick Co Md

10-NAME OF FATHER,

James Mullin

11-BIRTHPLACE OF FATHER
(State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

Mildred Mahoney

13-BIRTHPLACE OF MOTHER
(State or Country).

Frederick Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Frank Sheeler

(Address)

2444 Druid Hill Ave.

15-

Filed JUN 16 1920

ROBERT E. KAUTER

BALTIMORE CITY CLERK

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 14th, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 2nd, 1919, to June 14th, 1920, that I saw her alive on June 14th, 1920, and that death occurred, on the date stated above, at 3:30 p.m. The CAUSE OF DEATH* was as follows:

Endocarditis and dilatation

(Duration).....yrs.....8.....mos.....ds.

CONTRIBUTORY
(Secondary)

Rheumatism

(Duration).....yrs.....2.....mos.....ds.

(Signed) Roy F. Phillips M. D.

June 15th, 1920 (Address) 1929 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

St. Mary's Novary June 17, 1920

20-UNDERTAKER

ADDRESS

Marta Mahoney & Sons 1827 W. North St.

N.B.—Every item of information should be given in plain terms, so that it may be properly understood. See instructions on back of certificate.

D44037

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44037

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Franklin Senior Hospital 16* WARD)2-FULL NAME *Patrick Maunion*(Residence in Baltimore: No. *1139 N Fulton Ave*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *(yrs., 63)* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) *Single*

6-DATE OF BIRTH,

unknown, 1855
(Month) (Day) (Year)

7-AGE,

65

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Plumber 059*
(b) General nature of industry, business, or establishment in which employed (or employer). *Retired*9-BIRTHPLACE, (State or Country), *Ireland*10-NAME OF FATHER, *Patrick Maunion*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER *Mary Hyland*13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Annie Maunion*(Address) *1139 N Fulton Ave*

15-

JUN 16 1920

ROBERT E. KRAUTER

BRIAN F. FLYNN, CLERK

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 14, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy(Duration) yrs. mos. *2 hrs*CONTRIBUTORY *arterio sclerosis & heart* (Secondary)

(Duration) yrs. mos. ds.

(Signed) *James M. Remington* M. D. (Coroner.)*June 15, 1920* (Address) *70 E Chase St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place *Franklin Senior Hospital* In the of death.... yrs. mos. *2 hrs* State.... yrs. mos. ds.

When was disease contracted, if not at place of death?.....

*Calhoun St. Lafayette Ave*Former or usual residence *1139 N Fulton Ave*

19-PLACE OF BURIAL OR REMOVAL,

Cathedral *June 17 1920*

20-UNDERTAKER

Martin Harvey & Sons 827 North

ADDRESS

N. B.—Every item of information should be carefully supplied in plain terms, so that it may be properly classified. Cause of DEATH important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44038

CERTIFICATE OF DEATH.

152
REGISTERED NO. C

D44038

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 244 h Rose St. 6

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 244 n Rose St.

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

June 14, 1920
(Month) (Day) (Year)

7-AGE,

yrs. mos. 1.4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Child. 000

9-BIRTHPLACE,
(State or Country),

Baltimore Md.

10-NAME OF FATHER,

Hunter William C.

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore Md.

12-MAIDEN NAME OF MOTHER

Marie Conrad

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Hunter William C.

(Address) 244 n. Rose St.

15-JUN 16 1920

ROBERT E. KRAUTER

Filed..... 191.....

Burial Permit 01842 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 14, 1920 to June 15, 1920, that I saw him alive on June 14, 1920, and that death occurred, on the date stated above, at 1230 A.M.

The CAUSE OF DEATH* was as follows:

Hælectasis neonatorum

(Duration)..... yrs. mos. 1.4 ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) Albert C. C. C. M. D.

June 15, 1920 (Address) 2027 E. Kent Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Church June 16, 1920

20-UNDERTAKER

Mrs. C. Miller 2334 Jefferson

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44039

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 S Bouldin ST. 26 WARD)

2-FULL NAME

Katherine Pagliughi.

(a) RESIDENCE. NO.

205 S Bouldin ST. 26 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs. 2 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar 22, 1919

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.

1

1

25

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

None

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

Md.

10 NAME OF FATHER

Giuseppi Pagliughi

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Italy

12 MAIDEN NAME OF MOTHER

Mary Gambelli

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Italy

14

Informant
(Address)Giuseppi Pagliughi
205 S Bouldin

15

Filed

JUN 16 1920

ROBERT A. KAUTER
Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 16 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 1, 1920, to June 16, 1920,

that I last saw her alive on June 15, 1920,

and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Dile Colitis

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds. 16

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Persano, M. D.
June 16, 1920
2314 E. Baito St.
(Address)* State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St Vincent's Church

20 UNDERTAKER

J. Herwig & Co

DATE OF BURIAL

June 17, 1920

ADDRESS

2008 Orleans

Information should be carefully supplied, so that it may be properly
CAUSE OF DEATH in plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44040

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO. C

D44040

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Charles Kleinjohn

(Residence in Baltimore: No.

2711 E Madison

St.; yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Aug 9

1855

(Month) (Day) (Year)

7-AGE,

64 yrs., 9 mos., 5 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Park

(b) General nature of industry, business, or establishment in which employed (or employer).

Policeman

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Anna Kleinjohn

(Address)

2711 E Madison

15-

Filed

JUN 16 1920

ROBERT F. KAUTER

Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 14, 1920, 191...

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 11, 1920, to June 14, 1920,

that I saw him alive on June 14, 1920,

and that death occurred, on the date stated above, at 2 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. R. Kauter M. D.

6-14, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Cemetery

June 17, 1920

20-UNDERTAKER

ADDRESS

John Herwig & Co

2008 Cream

N.B.—Every item of information is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44041

CERTIFICATE OF DEATH.

D44041

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia Beall(a) RESIDENCE. No. 1720 Divison St.ST. 14 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

Female

Black

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

48

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Housework

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Mary's County,
(State or country) Md.10 NAME OF FATHER John Beall11 BIRTHPLACE OF FATHER (city or town) St. Mary's
(State or country) Md.12 MAIDEN NAME OF MOTHER Rebecca Sommerfeldt13 BIRTHPLACE OF MOTHER (city or town) St. Mary's
(State or country) Md.

14

Informant
(Address)Hospital Records,
New City Hospital.15 JUN 16 1920ROBERT B. LAUTER
Registrar

Burial Permit Stamp

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 19 20

17

I HEREBY CERTIFY, That I attended deceased from
May 30, 19 20, to June 13, 19 20.that I last saw her alive on June 14, 19 20.and that death occurred, on the date stated above, at 3:15 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerotic Hypertension,
Chronic Diffuse Nephritis;CONTRIBUTORY Hemiplegia A. (Thrombotic)
(Secondary) (duration) 8 yrs. 8 mos. 8 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? no special test
(Signed) J. J. Pessel, M. D.(Address) New City Hospital*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral CityJune 18, 1920

20 UNDERTAKER

ADDRESS

Felix B. Pye Sr2 MulberryInformation should be carefully supplied in plain terms, so that it may be properly
CAUSE OF DEATH in plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO *Johns Hopkins Hosp. ST. 19th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *William Oden*(a) RESIDENCE. NO *1700 W. Mulberry St.* WARD.(Usual place of abode)
Length of residence in city or town where death occurred *Life* mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Caucasian* 5 Single, Married, Widowed, or Divorced (write the word) *Child*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *Child*6 DATE OF BIRTH (month, day, and year) *Dec 1918*
7 AGE Years *1* Months *6* Days *—* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.* (State or country)10 NAME OF FATHER *Arthur Oden*11 BIRTHPLACE OF FATHER (city or town) *Baltimore, Md.* (State or country)12 MAIDEN NAME OF MOTHER *Grace Green*13 BIRTHPLACE OF MOTHER (city or town) *Charles County, Md.* (State or country)14 Informant *Hospital Record* (Address) *J. H.*15 File *JUN 16 1920* *ROBERT F. KRAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 14* 19*20*17 I HEREBY CERTIFY, That I attended deceased from *June 2-10*, 19*20*, to *June 14*, 19*20*, that I last saw him alive on *June 14*, 19*20*, and that death occurred, on the date stated above, at *3:45 PM* m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia overCONTRIBUTORY (Secondary) *Empyema* (duration) yrs. *1* mos. *7* ds.18 Where was disease contracted *Home* if not at place of death?Did an operation precede death? *Yes* Date of *June 3, 1920*Was there an autopsy? *No*What test confirmed diagnosis? *Operation*(Signed) *Harold L. Higgins*, M. D.June 15, 1920 (Address) *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Mount Vernon City* DATE OF BURIAL *June 16* 19*20*20 UNDERTAKER *Felix B. Pye Sr.* ADDRESS *2 Mulberry*

mation should be carefully read in plain terms, so that it may be understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44043

D44043

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Aged Men & Womans Home

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

1622 David Hill

ST. 14 WARD)

2-FULL NAME

Emma Truett

(a) RESIDENCE. No.

1622 David Hill

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

2 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female Colored

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 1845

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

75

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

md

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

M. M. Carroll

1622 David Hill

15

JUN 16 1920

ROBERT A. FLAUGER

Burial Permit Only

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 15 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 8

1920, to

June 10 1920

that I last saw her alive on

June 15 1920

and that death occurred, on the date stated above, at

7 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction or Volvulus.

(duration),

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Phys. exam.

(Signed)

Edward D. Wheeler

M. D.

1/16, 1920 Address)

1220 David Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Burial Ground

June 17 1920

20 UNDERTAKER

ADDRESS

John H. Treadwell

172

D44047

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 Outaw Place St.; 14 WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. 1908 Outaw Place St.; 58 yrs., 3 mos., 25 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE, <u>White</u>	5-SINGLE; MARRIED; WIDOWED; OR-DIVORCED; (Write the word.) <u>Married</u>
6-DATE OF BIRTH, <u>February</u> <u>19</u> , <u>1862</u> (Month) (Day) (Year)		
7-AGE, <u>58</u> yrs., <u>3</u> mos., <u>25</u> ds.		IF LESS than 1 day,hrs. or....min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work..... <u>at home</u> (b) General nature of industry, business, or establishment in which employed (or employer)..... <u>037</u>		

9-BIRTHPLACE,
(State or Country),Baltimore

10-NAME OF FATHER,

Romulus R. Griffith11-BIRTHPLACE OF FATHER
(State or Country),Baltimore

12-MAIDEN NAME OF MOTHER

Alveta Griffith13-BIRTHPLACE OF MOTHER
(State or Country),Baltimore

14-THIS ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank E. Monroe(Address) 1908 Outaw Place

15-

ROBERT R. KAUTER

FILED

JUN 16 1920

Baltimore City Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1920, to June 14 1920, that I saw her alive on June 14 1920, and that death occurred, on the date stated above, at 7 P. m. The CAUSE OF DEATH* was as follows:

Artistic Deformity(Duration) 10 yrs., 6 mos., 9 ds.CONTRIBUTORY
(Secondary)(Duration) 6 yrs., 6 mos., 9 ds.(Signed) Walter H. White M. D.June 14 1920 (Address) 2800 St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Greenmount Cemetery

DATE OF BURIAL,

June 16 1920

20-UNDERTAKER

Chas. S. Black 942 W. North Ave.

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1368 Calhoun ST.: 15 WARD)2-FULL NAME James Curtis(a) RESIDENCE. NO. 1368 Calhoun ST.,

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M4 COLOR OR RACE C5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 25-18607 AGE 59 Years 5 Months 20 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind.10 NAME OF FATHER James Curtis11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind.12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind.14 Informant (Address) James Curtis Jr 1368 Calhoun St15 Filed JUN 16 1920ROBERT E. LAUTER Registrar
Burial Permit Clerk

WARD.

(If nonresident give city or town and State)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/11 192017 I HEREBY CERTIFY, That I attended deceased from 4/1 1920 to 6/11 1920, that I last saw him alive on 6/11 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chr. infection - embolus
ac. hepatitis & subacuteCONTRIBUTORY (Secondary) Exhaustion (duration) yrs. 1 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) B. R. Butler, M. D.19 (Address) 2139 Dwyer St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

Geo. H. Holland

ADDRESS

1631 Union Hill

N. B.—When filled out, this certificate should be carefully supervised so that it may be properly filed. Information should be carefully supplied in plain terms, so that it may be properly filed. CAUSE OF DEATH in plain terms, so that it may be properly filed. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44046

CERTIFICATE OF DEATH.

38 D44046

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. NewCity HospitalST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Bracco(a) RESIDENCE. No. 2017 Oak St.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widower

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 18 51

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
69				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Queen Anne Co., Md.
(State or country)10 NAME OF FATHER William Bracco11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)14 Informant Hospital Records
(Address) New City Hospital

15 JUN 16 1920

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13, 19 2017 I HEREBY CERTIFY, That I attended deceased from June 8, 19 20 to June 13, 19 20.
that I last saw him alive on June 13, 19 20.and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic & multiple urinary fistulaeCONTRIBUTORY (Secondary) Broncho pneumonia
(duration) unknown yrs. mos. ds.18 Where was disease contracted if not at place of death? unknownDid an operation precede death? yes Date of June 12/20Was there an autopsy? noWhat test confirmed diagnosis?
(Signed) Frank T. Barker, M. D.June 13 1920 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laurel DATE OF BURIAL June 16 19 20

20 UNDERTAKER

Dr. Holland ADDRESS 1631 Union Hill

N. B.—Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly certified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44047

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

906 G. Lombard

ST.;

18

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Margaret A. Beuxbaum

(Residence in Baltimore: No.

906 G. Lombard

St.;

yrs., 6 mos., 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, 7 4-COLOR OR RACE, W. 5-SINGLE, MARRIED, DIVORCED, *Widowed*
(Write the word.)

6-DATE OF BIRTH,

Dec 13, 1919
(Month) (Day) (Year)

7-AGE,

6 yrs., 6 mos., 2 ds.

If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Calif.

10-NAME OF FATHER,

Joseph O. Beuxbaum

11-BIRTHPLACE OF FATHER
(State or Country),

Calif.

12-MAIDEN NAME OF MOTHER

Ruth Hunter

13-BIRTHPLACE OF MOTHER
(State or Country),

Calif.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Joseph O. Beuxbaum

(Address).....

906 G. Lombard St.

15-

JUN 16 1920

ROBERT E. KRAUTER

Baltimore, Md.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 10 1920, to June 15 1920, that I saw him alive on June 14 1920, and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Pneumonia

(Duration).....yrs.....mos.....14 ds.

CONTRIBUTORY
(Secondary)

Cardiac Asthma

(Duration).....yrs.....mos.....3 ds.

(Signed) Edgar M. Moulton M. D.

6/15/20 (Address) 30 W. Fullerton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral Cemetery

20-UNDERTAKER John J. Cowan & Son 907 Holliday St.

N. B.—Every item on back of certificate is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44048

CERTIFICATE OF DEATH.

28 D44048
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry F. Bollman(a) RESIDENCE. NO. 720 W. Hamburg St.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married.5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18 587 AGE Years Months Days If LESS than 1 day, hrs. or min.
62

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker 014

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)10 NAME OF FATHER John Bollman11 BIRTHPLACE OF FATHER (city or town) Hanover
(State or country) Germany12 MAIDEN NAME OF MOTHER Mary Tinaman13 BIRTHPLACE OF MOTHER (city or town) Hanover
(State or country) Germany14 Informant Hospital Records(Address) New City Hospital.15 JUN 16 1920 ROBERT E. KRAUTER
Registrar
Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 192017 I HEREBY CERTIFY, That I attended deceased from
June 2, 1920 to June 14, 1920
that I last saw him alive on June 14, 1920
and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Fibroid Tuberculosis.(duration) 2 yrs. mos. ds.CONTRIBUTORY Tuberculous Pneumonia
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? CityDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? No sputum test(Signed) J. F. Pessel, M. D.15. 1920 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London ParkJune 17- 1920

20 UNDERTAKER

Wm. Cook.

ADDRESS

502 E MtInformation should be carefully noted in plain terms, so that it may be properly
CAUSE OF DEATH in plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

D44049

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

913 N. S. Street 16

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

George C. Scherick

(Residence in Baltimore: No.

913 N. S. Street

St.: 44 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

May 16, 1861

7-AGE,

57 yrs., 1 mos., da.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Waldman

9-BIRTHPLACE, (State or Country),

Phil Pa

10-NAME OF FATHER,

Henry Scherick

11-BIRTHPLACE OF FATHER (State or Country),

Penn

12-MAIDEN NAME OF MOTHER

Emily Sullivan

13-BIRTHPLACE OF MOTHER (State or Country),

Penn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Laura Scherick

(Address)

913 N. S. Street

15-

Filed

JUN 16 1920

191

ROBERT E. KRAUTER

Registrar

Burial Permit 0121

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 15, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1920, to June 15, 1920, that I saw him alive on June 15, 1920, and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Dilatation of the Heart due to Mitral regurgitation

(Duration) 1 yrs., 10 mos., 15 ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs., 10 mos., 15 ds.

(Signed)

Charles G. Clark, M. D.

June 15, 1920 (Address) 1306 N. S. Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

N. S. Street

DATE OF BURIAL,

June 18, 1920

ADDRESS,

N. S. Street

20-UNDERTAKER

N. S. Street

N. B.—Every item of information on back of certificate. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44050

CERTIFICATE OF DEATH.

40

D44050

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1836 N Chester ST.: 8 WARD)

2-FULL NAME

Sarah F Bodin

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

1836 N Chester

ST.

WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Henry Bodin6 DATE OF BIRTH (month, day, and year) Dec 6/18707 AGE Years 49 Months 6 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at 037

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

James Beaser

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Queen's Anne's Co. Md

12 MAIDEN NAME OF MOTHER

Sarah Jeff

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Queen's Anne's Co. Md

14

Informant (Address)

Henry Bodin 1836 N Chester St

15

Filed

JUN 16 1920

ROBERT A. KRISTEN

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1920

17 I HEREBY CERTIFY, That I attended deceased from

Apr 15 1920, to June 16 1920that I last saw her alive on June 15 1920and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Cardiac end of stomach, with obstruction.(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

Starvation(duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? yes

What test confirmed diagnosis?

tumor found(Signed) Wm S Watson M. D., 19 (Address) 2128 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery June 18 1920

20 UNDERTAKER

Wm S Watson 2128 St Paul St

Information should be carefully read in plain terms, so that it may be understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44051

CERTIFICATE OF DEATH.

157 D44051
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

Mt Hope Retreat

ST.

28th WARD

2-FULL NAME

George P. Klunk

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

Mt Hope Retreat

Life -
St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Single

6-DATE OF BIRTH,

Dec

11th

1852

(Month)

(Day)

(Year)

7-AGE,

67

yrs.

4 mos.

0 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Fire Repair - (2)

(b) General nature of industry, business, or establishment in which employed (or employer).

Repair - 086

Repairing -

9-BIRTHPLACE.

(State or Country).

Baltimore Md

10-NAME OF FATHER,

Jos M. Klunk

11-BIRTHPLACE OF FATHER

(State or Country).

Baltimore Md

12-MAIDEN NAME OF MOTHER

Harriet M. Klunk

13-BIRTHPLACE OF MOTHER

(State or Country).

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Records of Mt Hope

(Address).

Mt Hope Baltimore Md.

15-

JUN 16 1920

ROBERT A. ELLAUBER

Filed....., 191.....

Baltimore Police Dept.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 15, 1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide (hanging)

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Chronic Mania

(Duration)

37 yrs.

mos.

ds.

(Signed)

J. A. Hennessy

M. D.

(Coroner.)

June 15, 1920 (Address) 2802 E. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

37 yrs.

P mos.

ds.

In the

Life -

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?.....

Baltimore Md

Former or usual residence Baltimore Md

19-PLACE OF BURIAL OR REMOVAL,

London Park Cemetery

DATE OF BURIAL,

June 16, 1920

20-UNDERTAKER

STEWART & MOWEN COMPANY

ADDRESS

108 W. NORTH AVE.

N. B.—Every item of information should be carefully checked for accuracy. CAUSE OF DEATH in plain terms, so that it may be properly classified. Important. See instructions on back of certificate.

D44052

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44052

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME A. Merrill Addison(a) RESIDENCE. No. 1114 N. Eutaw St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

Male

White

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1849

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

71

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workCourt Commissioner(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)10 NAME OF FATHER William Addison11 BIRTHPLACE OF FATHER (city or town) Georgetown
(State or country)12 MAIDEN NAME OF MOTHER Eliza Jarault13 BIRTHPLACE OF MOTHER (city or town) Mississippi
(State or country)

14

Informant Hospital Records(Address) New City Hospital

15

Filed

, 19

ROBERT F. FLAUTER
Registrar

JUN 16 1920

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1920

17

I HEREBY CERTIFY, That I attended deceased from
May 26, 1920, to June 15, 1920that I last saw him alive on June 15, 1920and that death occurred, on the date stated above, at 7:15 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Testicle(duration) yrs. 6 mos. ds.CONTRIBUTORY
(Secondary)Metastases to Retroperitoneal
Lymph Glands (duration) yrs. 2 mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? No special tests(Signed) J. P. Perrell, M. D.6-16-20 Address) New City Hospital.*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

West River O.C. Md June 17, 1920

20 UNDERTAKER

STEWART & MOWEN COMPANY

(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.Information should be carefully
CAUSE OF DEATH in plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44053

CERTIFICATE OF DEATH.

81

D44053

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 Linden Av. ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Hughes(a) RESIDENCE. NO. 1401 Linden Av. ST. 14 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 3 mos. 19 ds. How long in U. S., if of foreign birth? 84 yrs. 3 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Hughes6 DATE OF BIRTH (month, day, and year) Feb. 18-18367 AGE Years 84 Months 3 Days 19 If LESS than 1 day, hrs. — or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) none(c) Name of employer none9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland10 NAME OF FATHER John McClellan11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland14 Informant Mrs Mary L. Lhis (daughter) (Address) 1427 Linden Ave15 Filed 19 ROBERT A. LEADY Registrar

JUN 16 1920

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 192017 I HEREBY CERTIFY, That I attended deceased from April 1, 19 20, to June 16, 19 20, that I last saw him alive on June 16, 19 20, and that death occurred, on the date stated above, at 2.45 a.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosisCONTRIBUTORY (Secondary) Myocardial failure (duration) 10 yrs. 7 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of —Was there an autopsy? YesWhat test confirmed diagnosis? Physicist's Examination (Signed) J. C. Smith M. D. , 19 (Address) 712 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Green Mount Cemetery June 18 192020 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

108 W. NORTH AVE.

nation should be carefully supervised. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *15* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *2129 Lynnhurst* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *32* yrs. mos. ds.

How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female**White**Married*

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

Joseph K. Kyell

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

32

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Michael Reagan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Texas Md.

12 MAIDEN NAME OF MOTHER

Margarete Kiggins

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Joseph Kyell 2129 Lynnhurst St.

15

File

*JUN 16 1920**ROBERT E. LESTER**Registrar*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 13 1920

17

I HEREBY CERTIFY, That I attended deceased from

*May 29 1920 to June 13 1920*that I last saw her alive on *June 13 1920*and that death occurred, on the date stated above, at *7:20 P.M.*

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *Yes* Date of *June 1, 1920*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Arthur Chas. Tiernan* M. D.6/13, 1920 (Address) *Md. Gen'l. Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery 6/17 1920

20 UNDERTAKER

*J. J. Moran**E. B. B. B.*

Information should be given in plain terms, so that it may be understood by all. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3973 Foster Ave.* ST. *26* WARD)

2-FULL NAME

(a) RESIDENCE. No. *3973 Foster*

(Usual place of abode)

Length of residence in city or town where death occurred *70* yrs.

mos.

ds.

How long in U. S., if of foreign birth? *Life* yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

*Married*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Elizabeth Hock*

6 DATE OF BIRTH (month, day, and year)

Feb. 10-1865

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*55**4**4*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Boiler maker

(b) General nature of industry, business, or establishment in which employed (or employer)

Bethlehem Steel

(c) Name of employer

*Corp. Pottsville*9 BIRTHPLACE (city or town)
(State or country)*Pa.*

10 NAME OF FATHER

Jacob Hock

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Barbara Zurb

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant
(Address)*Elizabeth Hock*
3973 Foster Ave

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 14 1920

17

HEREBY CERTIFY, That I attended deceased from

June 8, 1920, to *June 14*, 1920,that I last saw him alive on *June 14*, 1920,and that death occurred, on the date stated above, at *10.25 P. m.*

The CAUSE OF DEATH* was as follows:

R. Lobar Pneumonia

(duration) yrs.

mos. *7* ds.CONTRIBUTORY
(Secondary)*Toxemia*

(duration) yrs.

mos. *2* ds.

18 Where was disease contracted

if not at place of death?

at place of death

Did an operation precede death?

no Date of *none*

Was there an autopsy?

no

What test confirmed diagnosis?

Chemical examination

(Signed)

W. L. Burke

M. D.

June 5, 1920 (Address)

3042 Hudson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

 *Sacred Heart Cem.**June 17 1920*

20 UNDERTAKER

Lilly and Ziehl

ADDRESS

4038 W. 1st St.

JUN 16 1920

D44056

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44056

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy St.* ST. *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Isaac W. Merritt*(a) RESIDENCE. No. *376 Park Ave.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2* yrs. mos. ds.How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 COLOR OR RACE *W.*5 Single, Married, Widowed, or Divorced (write the word) *Married.*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Fannie S. Merritt*6 DATE OF BIRTH (month, day, and year) *01/13/1887*

7 AGE

Years *44*Months *8*Days *3*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Salmon*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *F. W. MacCarthy Co.*9 BIRTHPLACE (city or town) (State or country) *Ala.*10 NAME OF FATHER *J. W. Merritt*11 BIRTHPLACE OF FATHER (city or town) (State or country) *New York*12 MAIDEN NAME OF MOTHER *Joseph Constantine*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Mississippi*

14

Informant (Address) *Fanny S. Merritt 576 Park Ave.*

JUN 16 1920

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 16 1920*

17

I HEREBY CERTIFY, That I attended deceased from *6/12/20* 19 .. to *6/16/20* 19 ..that I last saw him alive on *6/16/20* 19 ..and that death occurred, on the date stated above, at *3:50 a.m.*

The CAUSE OF DEATH was as follows:

intestinal obstruction due to internal hernia.(duration) yrs. mos. *2* ds.CONTRIBUTORY (Secondary) *Sepsis*(duration) yrs. mos. *4* ds.18 Where was disease contracted if not at place of death? *at home*Did an operation precede death? *yes* Date of *6/14/20*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. R. Kelly* M. D.19 (Address) *Mercy St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Paul's Church *June 18 1920*

20 UNDERTAKER

ADDRESS *St. Paul's Church*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44057

D44057

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1749 Clifton Ave. ST. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 1749 Clifton Ave. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds.

How long in U. S., if of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Bernhard Schenck

6 DATE OF BIRTH (month, day, and year) May 10 1843

7 AGE 77 Years 1 Months 6 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Emil H. H. H.

11 BIRTHPLACE OF FATHER (city or town) (State or country) H. H.

12 MAIDEN NAME OF MOTHER H. H.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) H. H.

14

Informant (Address)

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1920

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1920, to June 16, 1920.

That I last saw him alive on June 15, 1920.

and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriologist

(Signed) H. S. Kerner, M. D.

June 12, 1920 Address 1301 N. Pat Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer June 18 1920

20 UNDERTAKER ADDRESS

H. S. Kerner

JUN 16 1920

Burial Permit Clerk

Information should be given in plain terms, so that it may be understood. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44058

D44058

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Foster(a) RESIDENCE. NO. 114 W. Barre St. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Widowed</u>
----------------------	---------------------------------	--

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<u>49</u>			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Brewer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Unknown9 BIRTHPLACE (city or town)
(State or country)New YorkNew York10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town)
(State or country)Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Unknown14 Informant Hospital Records(Address) M.T.H.15 Filed Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16th 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 2nd, 1920, to June 16th, 1920.that I last saw him alive on June 15th, 1920.and that death occurred, on the date stated above, at 6.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) 3 yrs. mos. ds.CONTRIBUTORY
(Secondary)(duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?UnknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis T. B. in sputum(Signed) George S. Wilkin M. D.6-16-20 Address Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

W. Cross Cem. June 18-1920

20 UNDERTAKER

William Cook

ADDRESS

5235 North

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates.

JUN 16 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44059

CERTIFICATE OF DEATH.

79 D44059
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 N Schroeder ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 225 N Schroeder St.; 54 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

WLT

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Mar

6-DATE OF BIRTH,

May 26, 1866
(Month) (Day) (Year)

7-AGE,

54 yrs., 0 mos., 20 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Elevator 086
Conductor9-BIRTHPLACE,
(State or Country),

Balto

10-NAME OF FATHER

Conrad Freyer

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Margaret Freyer

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Catherine Freyer
(Address) 225 N. Schroeder St.

15-

Robert P. Harrison,

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 15, 1918
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 2, 1918, to June 15, 1918,that I saw h..... alive on June 15, 1918,and that death occurred, on the date stated above, at 430 m.

The CAUSE OF DEATH* was as follows:

Organic Disease
of Heart
about
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

J. H. Harrison, M. D.
(Address) 939 N. Taylor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Randall Park

DATE OF BURIAL,

June 18, 1918

20-UNDERTAKER

Geo. J. Smith

ADDRESS

Fayette St.

CAUSE OF DEATH in part important. See instructions on back of certificate.

JUN 18 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D44060

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. *Hopkins Hospital* ✓)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Thomas Cooper(Residence in Baltimore: No. *1608 Alicanna*.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*col.*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Mar*

6-DATE OF BIRTH,

(Month) (Day) (Year) *1*

7-AGE,

3 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *none*
(b) General nature of industry, business, or establishment in which employed (or employer) *000*9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *Thomas Cooper*11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*12-MAIDEN NAME OF MOTHER *Maud Jones*13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Maud Cooper*(Address) *1608 Alicanna St*

15-

JUN 17 1920

101

ROBERT E. LAUTER

DEPUTY REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic fall down stairs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Ray J. [Signature]*

(Coroner.)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Laurel*DATE OF BURIAL, *June 17, 1920*

20-UNDERTAKER

*John W. Henderson*ADDRESS *1502 E. [Signature]*

N. B.—Every item of information should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44061

CERTIFICATE OF DEATH.

REGISTERED NO.

D44061

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Hooper

(a) RESIDENCE. No. Unknown

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 70

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records

(Address) New City Hospital.

15 Filed 19 ROBERT E. KRAUTER Registrar

JUN 17 1920

Serial Permit 0111

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1920, to June 15, 1920, that I last saw her alive on June 14, 1920, and that death occurred, on the date stated above, at 8:30 A. M.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis & Hypertension

unknown (duration) yrs. mos. ds.

CONTRIBUTORY Chr. Diffuse Nephritis (Secondary)

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No special tests; Urine

(Signed) J. J. Pessel M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL New City Hospital

DATE OF BURIAL June 17 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL June 17 1920

20 UNDERTAKER

ADDRESS 1502

John W. Henderson & Monument

CAUSE OF DEATH in plain terms, so that it may be understood by the layman. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44063

D44063

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1716 Jackson ST. 24 WARD)

2-FULL NAME

(a) RESIDENCE, NO. 1716 Jackson ST. 24 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

3

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

Filed

JUN 17 1920

ROBERT B. KAUFER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, that I attended deceased from Jun 13, 1920, to Jun 16, 1920, that I last saw her alive on Jun 16, 1920, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth (3 MO)

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Campbell, M. D.

16, 1920 (Address) 1644 Hancock

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Ex 13 Harle

115 E West St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44061

CERTIFICATE OF DEATH.

151 D44061
REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1716 Jackson ST., 24 WARD

2-FULL NAME Deceased Mrs. Mary H. Floyd

(a) RESIDENCE. No. 1716 Jackson ST., 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13, 1920
7 AGE Years Months Days If LESS than 1 day, hrs. or min. 3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Ross H. Floyd

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary H. Montgomery

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant (Address) Ross H. Floyd 1716 Jackson St.

15 JUN 17 1920 ROBERT E. FRANKLIN

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1920

17 I HEREBY CERTIFY, that I attended deceased from June 13, 1920, to June 16, 1920, that I last saw her alive on June 16, 1920, and that death occurred, on the date stated above, at 11 A. m. The CAUSE OF DEATH* was as follows:

Premature Birth (7 mo)

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds. 3

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Histology (Signed) M. C. Campbell, M. D.

16, 1920 (Address) 1644 Hancock

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cedar Hills June 17, 1920

20 UNDERTAKER ADDRESS

Ex 13 Harle 115 E. North

Barial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44065

CERTIFICATE OF DEATH.

D44065

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 N. Rose ST.; 6 WARD)

2-FULL NAME

(Residence in Baltimore: No. 201 N. Rose St. 64 yrs., 6 mos. 11 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Bath Butterhoff(Address) 201 N. Rose St.

15-

JUN 17 1920 ROBERT E. ERAUTER

Filed..... 191..... BURIAL PERMIT..... REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

June 15, 1920 to June 15, 1920that I saw him alive on June 15, 1920and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage20 - 25 min.

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart weakness

(Duration)..... yrs. mos. ds.

(Signed) J. C. Reiser M. D.6/17, 1920 (Address) 2600 N. Myrtle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Holy Redeemer June 18, 1920

20-UNDERTAKER ADDRESS

J. J. Kerr 156 N. Luzerne

CAUSE OF DEATH in plain terms important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44066

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Ward Lickings Sanitarium*CITY OF BALTIMORE: (No. *Harmon Ave*)ST. *25* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Jefferson G. Thalacker*(a) RESIDENCE. NO. *Washington A. C.*

ST.

WARD.

Washington Lee.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1* yrs. *6* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *married*
*husband*6 DATE OF BIRTH (month, day, and year) *Oct. 8 - 1858*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
61 *8* *7*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Merchant*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *West Virginia*
(State or country)10 NAME OF FATHER *Henry Thalacker*11 BIRTHPLACE OF FATHER (city or town) *Germany*
(State or country)12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) *Germany*
(State or country)14 Informant *Mr. H. R. Thalacker*
(Address) *Washington A. C. 810 Maryland*15 File *JUN 17 1920* *ROBERT E. KRAUTER*
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 15* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from *January*, 19*18*, to *June*, 19*20*,that I last saw him alive on *June 12*, 19*20*,and that death occurred, on the date stated above, at *1:15 P. m.*

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonum
& Meningitis(duration) *1* yrs. *4* mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted *Washington A. C.*
if not at place of death?Did an operation precede death? *no* Date of *-*Was there an autopsy? *no*What test confirmed diagnosis? *yes*(Signed) *A. H. R. Meyer*, M. D.11-16, 1920 (Address) *2435 Cedar Place*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**June 17 1920*

20 UNDERTAKER

ADDRESS

*H. J. Tickner & Sons**N. Y. Pa.*

CAUSE OF DEATH in plain terms, so that it can be read by anyone. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44067

CERTIFICATE OF DEATH.

20 D44067

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5210 Palmer Ave 27

ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 5210 Palmer Ave

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male White

4-COLOR OR RACE,

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH,

JUN 28, 1861
(Month) (Day) (Year)

7-AGE,

58 yrs. 6 mos. 18 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Butcher 013

9-BIRTHPLACE,

(State or Country),

Balt. Md

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

ROBERT E. ELLIOTT

JUN 17 1920

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

JUN 5, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest, autopsy or inquiry,

thereon and from the evidence obtained by said inquest, autopsy or inquiry,

and that said deceased came to death on the day stated above.

18-CAUSE OF DEATH* was as follows:

Accidental accident
to foot, caused by
Blood poisoning
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) John J. Morrison, M. D.
JUN 10 1920 (Address) 7522 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?...

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL

JUN 17 1920

20-UNDERTAKER

Wm J. Pickens

ADDRESS

714 Pa.

N. B.—Every item of information should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44068

CERTIFICATE OF DEATH.

120 D44068

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME C. Richard Worley(a) RESIDENCE. No. Unknown (913 N. Stricker) ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18577 AGE 63 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Wales
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)14 Informant Hospital Records.(Address) New City Hospital.

15 JUN 17 1920

ROBERT E. ELLIOTT

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1920

17

I HEREBY CERTIFY, That I attended deceased from April 26, 1920, to June 16, 1920, that I last saw him alive on June 15, 1920, and that death occurred, on the date stated above, at 5:50 A. m.
The CAUSE OF DEATH* was as follows:Chronic SautCONTRIBUTORY (Secondary) Chronic Diffuse Nephritis
(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Urine & Blood
(Signed) J. F. Persel M. D.June 16 1920 address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Cem

20 UNDERTAKER

Robert Brooks & Son

DATE OF BURIAL

6-18 1920

ADDRESS

175 Calhoun

CAUSE OF DEATH in plain terms, so that it may be understood by the layman. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE, in months, if under 1 year, must be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D44069

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

DATE OF BIRTH

AGE

If LESS than 1 day, 1/2-hrs. or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (State or country)

NAME OF FATHER

BIRTHPLACE OF FATHER (State or country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (State or country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

JUN 17 1920

ROBERT F. REAUTE

Filed, 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

6 mo gestation
lived 12 hours
Premature

Contributory (SECONDARY)

(Signed), M. D.

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44070

CERTIFICATE OF DEATH.

91✓
D44070
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 Wellington Ave ST. 13 WARD)

2-FULL NAME

(Residence in Baltimore: No. 811 Wellington St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Apr. 1920
(Month) (Day) (Year)

7-AGE,

2 yrs. 2 mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Balto City

10-NAME OF FATHER,

Albert Deumer

11-BIRTHPLACE OF FATHER (State or Country),

Phila Pa

12-MAIDEN NAME OF MOTHER

John Hedrick

13-BIRTHPLACE OF MOTHER (State or Country),

Balto Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Albert Deumer

(Address)

811 Wellington

15-

JUN 17 1920

Filed

ROBERT A. EBAUTER

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 17, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 15, 1920, to June 17, 1920,

that I saw him alive on June 17, 1920,

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Tubercular Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)

S. R. Warrick M. D.

6/17/20, 191... (Address) 865 W. 36th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St Marys N. 1920

20-UNDERTAKER

A. J. Marshall 3339 1/2 Rd

CAUSE OF DEATH IN plain terms important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 34 D44072 5 WARD)2-FULL NAME Willet Masterson(a) RESIDENCE. NO. 1031 Hillen St. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18657 AGE Years 55 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) (State or country) Missouri10 NAME OF FATHER Chas. W. Masterson11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland12 MAIDEN NAME OF MOTHER Pheobe Houghton13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky14 Informant Hospital Records (Address) M.T.H.15 ROBERT A. LEAUTE Registrar Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13, 192017 I HEREBY CERTIFY, That I attended deceased from November 21, 1919, to June 13, 1920.that I last saw him alive on June 13, 1920.and that death occurred, on the date stated above, at 4.20 p. m.

The CAUSE OF DEATH* was as follows:

Uremia(duration) yrs. 7 mos. ds. CONTRIBUTORY Tuberculous nephritis, epidi-
(Secondary) orchitis, 3 (?) yrs. mos. ds. 18 Where was disease contracted Unknown
if not at place of death?Did an operation precede death? No Date of Was there an autopsy? What test confirmed diagnosis? (Signed) George R. W. Leake, M. D.6-14-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF , CREMATION Bay View Hospital

DATE OF BURIAL

6/16 1920

20 UNDERTAKER

J. B. Munger

ADDRESS

BCH

CAUSE OF DEATH in plain terms, so that it can be read by anyone. See instructions on back of certificates.

D44072

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 D44072

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. *4th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Spencer

(a) RESIDENCE. No.

738 W. Lexington St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Five* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

May 8-1920

7 AGE

Years

1 Months*2* Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Wm. Spencer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

M. C.

12 MAIDEN NAME OF MOTHER

Betty Halls

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

M. C.

14

Informant (Address)

Hospital Record J. H. H.

15

JUN 17 1920

ROBERT E. ELAFTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 10 1920

17

I HEREBY CERTIFY, That I attended deceased from

*June 9, 1920, to June 10, 1920*that I last saw him alive on *June 10, 1920*,and that death occurred, on the date stated above, at *6:00* m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage - (Birth injury)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *Autopsy*(Signed) *Harold L. Higgins* M. D., 19 (Address) *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

19

20 UNDERTAKER

Commissioner Health

ADDRESS

FAC. WM. E. WOODALL

CAUSE OF DEATH IN plain language. See instructions on back of certificate. TION is very important.

D44073

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. 38 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH, *Oct 7th, 1875*
(Month) (Day) (Year)

7-AGE, *44* yrs. *8* mos. *9* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer). *03*

9-BIRTHPLACE, (State or Country), *Bohemia*

10-NAME OF FATHER, *Mathias Zeman*

11-BIRTHPLACE OF FATHER, (State or Country), *Bohemia*

12-MAIDEN NAME OF MOTHER, *Not Given*

13-BIRTHPLACE OF MOTHER, (State or Country), *Not Given*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank P. P. Jr.*

(Address) *825 N. Lexington St.*

15- *ROBERT J. LAUTER*

Filed *JUN 17 1920* *101*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 16, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

suicide by pistol.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) *None*

(Signed) *M. D. J. J. J.* M. D.

(Coroner) *June 16, 1920* (Address) *825 N. Lexington St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer*

DATE OF BURIAL, *June 19, 1920*

20-UNDERTAKER, *Geo. M. Smith & Son*

ADDRESS, *811 N. W. 4th*

N. B.—Every item of information furnished in plain terms, so that it may be properly understood. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044074

1044074

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Patterson Ph. swimming pool*)

WARD)

FULL NAME

Edward Koterwas

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *2106 Eastern ave*)St. *8* yrs., *0* mos. *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*white*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

*Sept**X**1912*

7-AGE,

*8**10*If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).*School.*9-BIRTHPLACE,
(State or Country),*Baltimore*10-NAME OF
FATHER,*Nicenty Koterwas*11-BIRTHPLACE
OF FATHER
(State or Country),*Poland*12-MAIDEN NAME
OF MOTHER*Sofia Jaszycki*13-BIRTHPLACE
OF MOTHER
(State or Country),*Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Nicenty Koterwas*(Address) *2106 Eastern*

15-JUN 17 1920

ROBERT R. KRAUTER

Filed.....

191...

Baltimore Health Department Registrar.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH,

*June**15**1920*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry, and that said deceased came to death
on the day stated above.

The CAUSE OF DEATH* was as follows:

*Drowned, Patterson Ph.
swimming pool.
Duration..... yrs..... mos..... ds.*CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *M. J. Isales* M. D.647... (Address) *647... 100**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS-
FERENTS, OR RECENT RESIDENTS).At place In the
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

6/17

20-UNDERTAKER

M. Halkowski 1618 Eastern

ADDRESS

N.B.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44075

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 614 S. Seward St. 1 WARD)
2-FULL NAME Harry Stewart Bonebrake
(Residence in Baltimore: No. 614 S. Seward St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male
4-COLOR OR RACE, white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married
6-DATE OF BIRTH, April 12, 1873
(Month) (Day) (Year)

7-AGE, 46 yrs. 2 mos. 4 ds.
If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, musician
(b) General nature of industry, business, or establishment in which employed (or employer), 0826

9-BIRTHPLACE, (State or Country), Pa

10-NAME OF FATHER, Harry G Bonebrake
11-BIRTHPLACE OF FATHER (State or Country), Pa
12-MAIDEN NAME OF MOTHER, Cora Walter
13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Bessie Bonebrake
(Address) 614 S. Seward

15-
Filed JUN 17 1920
ROBERT A. KRAUTER
Burial Place Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease
(Duration)yrs.mos.ds.

CONTRIBUTORY (Secondary)
(Signed) Henry S. G. D.
(Coroner)
(Address) 1610 E. Bell St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.mos.ds. In the State....yrs.mos.ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Daynestor Pa

DATE OF BURIAL, 6/18, 1920

20-UNDERTAKER, Mr. Fialkowski 168 Eastern Ave.

ADDRESS

D44076

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X120 D44076

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Md. General Hospital 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs Geneva Warfield Walkersville Md

(a) RESIDENCE, No.

(Usual place of abode)

WARD.

Walkersville Md.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

3

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

3

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND or WIFE of

Dr Clarence Warfield

6 DATE OF BIRTH (month, day, and year)

1875

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 837

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Wm. P. Nickles

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Don't Know

14

Informant (Address)

Dr. Clarence Warfield New Howard Hotel

15

Filed

JUN 17 1920

ROBERT E. BAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 15 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 14 1920 to June 15 1920

that I last saw him alive on June 15 1920

and that death occurred, on the date stated above, at 9:15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis & Chronic myocarditis

(duration) 5(3) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Urinalysis

(Signed)

T. E. Wright

M. D.

6/15, 1920 Address)

Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Millersville Md.

June 17 1920

20 UNDERTAKER

Harry H. Witzke

ADDRESS

1531 W. Lombard

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44077 CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital.ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Polton(a) RESIDENCE. NO. Unknown

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Black</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Widow</u>
------------------------	---------------------------------	---

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 18 59

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<u>61</u>				

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work Housework(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)10 NAME OF FATHER George Polton11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)12 MAIDEN NAME OF MOTHER Hester Porter June 14 1920 (Address) New City Hospital.13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)14 Informant Hospital Records(Address) New City Hospital15 JUN 17 1920 17:30 ROBERT A. LAUTER
Registrar
Serial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 19 2017 I HEREBY CERTIFY, That I attended deceased from
February 19, 19 20, to June 14, 19 20,
that I last saw her alive on June 14, 19 20,
and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia;(duration) yrs. 4 mos. ds.CONTRIBUTORY
(Secondary)(duration) yrs. 4 mos. ds.18 Where was disease contracted unknown
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No special test
(Signed) J. J. Perrell, M. D.*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

UNIVERSITY OF MARYLAND June 17 1920

20 UNDERTAKER

ADDRESS

Commissioner Health,

Per. Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

Catherine Anna Kohlbauser.
HEALTH DEPARTMENT—CITY OF BALTIMORE

D44078

CERTIFICATE OF DEATH.

REGISTERED NO.

D44078

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1747 E Eager ST.;

WARD)

2-FULL NAME

Catherine Anna Kohlbauser

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

1747 E Eager

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Alphus J. Kohlbauser

6 DATE OF BIRTH (month, day, and year)

Aug 31-1894

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

25

9

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Emilsburg, Md

10 NAME OF FATHER

John Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Agnes Gallagher 1525 N. 15th St

15

FILE

JUN 17 1920

ROBERT E. REUTER

Barial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 15 1920

17

I HEREBY CERTIFY, That I attended deceased from

Apr 3 1920, to June 15 1920,

that I last saw him alive on June 15 1920,

and that death occurred, on the date stated above, at 1:31 p. m.

The CAUSE OF DEATH* was as follows:

Endocarditis mitral valvular
Cardiac insufficiency (Mitral)
(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

History of Influenza
(duration) 11 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Valvular stenosis

(Signed) W. B. Burns, M. D.

June 19 (Address)

22152 Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Most Holy Redeemer

June 18 1920

20 UNDERTAKER

ADDRESS

Joseph Syfer

1600 W. North Ave

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44079

CERTIFICATE OF DEATH.

24 D44079
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5004 Alhambra ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph William Essert

(Residence in Baltimore: No. 5004 Alhambra Ave. yrs., mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male	4-COLOR OR RACE, white	5-SINGLE, <i>single</i> MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
----------------	---------------------------	--

6-DATE OF BIRTH, June 10, 1920
(Month) (Day) (Year)

7-AGE, If LESS than 1 day, yrs., mos., ds. hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Infant*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), 5004 Alhambra Ave

10-NAME OF FATHER, Joe. Essert

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Charlotte Perkins

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joe. Essert

(Address) 5004 Alhambra Ave

15-Filed JUN 17 1920

ROBERT A. KAUTER
Baptist Church

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 17, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 10 1920, to June 17 1920, that I saw him alive on June 16 1920, and that death occurred, on the date stated above, at 2²⁵ A. m. The CAUSE OF DEATH* was as follows:Tetanus
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) E. H. Duncan M. D.
June 17, 1920 (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Presbyterian Cemetery, June 17, 1920

20-UNDERTAKER, ADDRESS

Wm. Beck 512 E. North Ave

CAUSE OF DEATH in plain language important. See instructions on back of certificate.

D44080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 Diamond ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David S. Slouts

(a) RESIDENCE. NO. 314 Diamond ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't know

7 AGE 52 ~~40~~ 52 years old If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cecilville MD

10 NAME OF FATHER David Slouts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary Boston (Address) 314 Diamond

15 Filed JUN 17 1920 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1920, to Jan 15, 1920 that I last saw him alive on Jan 14, 1920 and that death occurred, on the date stated above, at 12:45 P.M. The CAUSE OF DEATH* was as follows:

Cerebral apoplexy (duration) since Jan 27-20 yrs. mos. ds. CONTRIBUTORY Anterior Sclerosis (Secondary) (duration) Don't know yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) W. K. General, M. D.

6/15, 1920 (address) 117 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Auburn Cem June 18 1920

20 UNDERTAKER ADDRESS 916

Daniel Easton

Burial Permit Clerk

CAUSE OF DEATH is printed in plain text on back of certificate. See instructions on back of certificate. TION is very important.

D44081

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44081

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Queen(a) RESIDENCE. No. 820 China St.

(Usual place of abode)

ST.

WARD.

Length of residence in city or town where death occurred 54 yrs.

mos.

ds.

How long in U. S., if of foreign birth Life yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1866

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.54

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)10 NAME OF FATHER John Queen11 BIRTHPLACE OF FATHER (city or town) Anne Arundel Co.
(State or country) Md.12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Anne Arundel Co.
(State or country)

14

Informant Hospital Records
(Address) New City Hospital.

15

Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1920

17

I HEREBY CERTIFY, That I attended deceased from
June 4, 1920, to June 15, 1920,
that I last saw him alive on June 14, 1920,
and that death occurred, on the date stated above, at 8:30 A. m.
The CAUSE OF DEATH* was as follows:Sclerosis Arteriosclerosis
and hypertension.
(duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)Terminal (duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? yes Date of 6-4-20Was there an autopsy? no

19 Was test confirmed diagnosis?

(Signed) Frank T. Barber, M. D.June 15, 1920 (Address) New City Hospital.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Peter'sJune 18, 1920

20 UNDERTAKER

Daniel Easton

ADDRESS

716
Quinn Ave

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates.

JUN 17 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44082

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 39 yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE

MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17 I HEREBY CERTIFY, That I attended deceased from

June 13 1920, to June 15 1920,

that I saw him alive on June 15 1920,

and that death occurred, on the date stated above, at 11 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Albert S. Driscoll M. D.

June 16 1920 (Address) 1211 Mulberry St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Cathedral June 18 1920

20-UNDERTAKER

ADDRESS

E. A. Wiedefeld

CAUSE OF DEATH in plain language important. See instructions on back of certificate.

JUN 17 1920

Robert P. Harrison,

Burial Permit Clerk.

D44083

HEALTH DEPARTMENT—CITY OF BALTIMORE

6-091044088

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 Vine ST.; 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1002 Vine St.; 1 yrs., 1 mos., 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. Male 4-COLOR OR RACE, C 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, S (Write the word.)

6-DATE OF BIRTH, June 16, 1919 (Month) (Day) (Year)

7-AGE, 1 yrs., 1 mos., 1 ds. If LESS than 1 day, 1 hrs. or 1 min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Officer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto10-NAME OF FATHER, Geo Miles11-BIRTHPLACE OF FATHER (State or Country), Annapolis Md12-MAIDEN NAME OF MOTHER, May Johnson13-BIRTHPLACE OF MOTHER (State or Country), Annapolis Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Updegraff(Address) 1002 Vine St

15-

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from June 14, 1920, to June 16, 1920, that I saw h alive on June 16, 1920, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Measles - Bronchopneumonia

CONTRIBUTORY (Secondary)

(Signed) John H. Wood M. D.191... (Address) 739 N. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 1 yrs., 1 mos., 1 ds. In the State 1 yrs., 1 mos., 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. AmbroseDATE OF BURIAL, June 17, 192020-UNDERTAKER, Brown & HillandADDRESS 114 N.

CAUSE OF DEATH IN PARTIALITY important. See instructions on back of certificate.

JUN 17 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44081

CERTIFICATE OF DEATH.

79 D44081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2700 Fairmount Ave. ST. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdalena Stroh

(a) RESIDENCE. NO. 2700 Fairmount Ave. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Widowed

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

George Stroh

6 DATE OF BIRTH (month, day, and year) Aug. 25 1844

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

75 9 21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Wendwig Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant Mary Stroh

(Address) 2700 Fairmount Ave.

15 Robert P. Harrison, Registrar

JUN 17 1920

Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1920

17 I HEREBY CERTIFY, That I attended deceased from 5-1, 1920, to 6-16, 1920,

that I last saw him alive on 6-15-1920,

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiovascular

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1024 Eastern Ave.

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Francis, M. D.

6/17, 1920 Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Bedar Hill Cemetery June 12 1920

20 UNDERTAKER ADDRESS

H. Vander & Son 1710 Fleet St.

D44085

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

D44085

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 208 S Robinson ST. 1 WARD)

2-FULL NAME William Bernard Garrett

(Residence in Baltimore: No. 208 S Robinson St. 2 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

March

2

1885

(Month)

(Day)

(Year)

7-AGE

35

yrs.

3

mos.

13

ds.

If LESS than

1 day,hrs.

or — mo.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

Time keeper 009

(b) General nature of industry, business, or establishment in which employed (or employer)

Can Can Co

9-BIRTHPLACE

(State or country)

Baltimore

10-NAME OF FATHER

Harry Garrett

11-BIRTHPLACE OF FATHER

(State or country)

Baltimore, Md.

12-MAIDEN NAME OF MOTHER

Lillie Parson

13-BIRTHPLACE OF MOTHER

(State or country)

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mabel B. Garrett

(Address)

208 S Robinson St.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June

15

1920

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from 1 May 1920 to 15 June 1920

that I saw him alive on 15 June 1920.

and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed), 25 + more M. D.

15 June 20 (Address) 301 S. Ellwood St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Lawn Cemetery

June 11 1920

20-UNDERTAKER

ADDRESS

H. Sander & Son

1710 Fleet St.

JUN 17 1920

Robert P. Harrison,

Burial Permit Clerk.

N. B.—Every item of information should be carefully supplied. Exact statement of state CAUSE OF DEATH in plain terms, so that it may be properly classified, is very important. See instructions on back of certificate.

D44086

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44086

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST.; *2nd* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Harold Bryant(a) RESIDENCE. NO. *733 S. McKeen Ave* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2 yrs* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Child*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Child*6 DATE OF BIRTH (month, day, and year) *May 22-1918*7 AGE *2* Years Months *24* Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.* (State or country)10 NAME OF FATHER *Charles Bryant*11 BIRTHPLACE OF FATHER (city or town) *Md.* (State or country)12 MAIDEN NAME OF MOTHER *Math. Jones*13 BIRTHPLACE OF MOTHER (city or town) *Md.* (State or country)14 Informant *Hospital Record* (Address) *26-26*15 Filled *Robert P. Harrison,* Registrar

JUN 17 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 15-1920*17 I HEREBY CERTIFY, That I attended deceased from *June 1, 1920* to *June 15, 1920* that I last saw him live on *June 15, 1920*, and that death occurred, on the date stated above, at *4:00 a.m.* The CAUSE OF DEATH* was as follows:*Primary Bronchopneumonia*(duration) yrs. mos. ds. *21*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted *home* if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *X-Ray - Blood Culture*(Signed) *Harold L. Higgins, M. D.*19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Carmel Cemetery June 11 1920

20 UNDERTAKER

H. Sander & Son 1712 Flaid St.

D44087

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2322 Fleet

ST.: 1 WARD)

2-FULL NAME

George S. Manns

ST.: WARD.

(If nonresident give city or town and State)

(a) RESIDENCE. NO.

2322 Fleet

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 8 1920

7 AGE

Years

Months

Days

9

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt

10 NAME OF FATHER

George Manns

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt

12 MAIDEN NAME OF MOTHER

Martha Hammer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt

14

Informant (Address)

George Manns

2322 Fleet

15

JUN 17 1920

Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 16 1920

17 I HEREBY CERTIFY, That I attended deceased from

June 11 1920, to June 16 1920.

that I last saw him alive on June 16 1920.

and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Weakness

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

Cardiac Fault

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

H. L. Carmel

Wendell Wyllie & Son

ADDRESS

378 Ann

D44088

HEALTH DEPARTMENT--CITY OF BALTIMORE D44088

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital.ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Bollinger.(a) RESIDENCE. NO. Unknown

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
56				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER Unknown June 17, 192013 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)14 Informant Hospital Records
(Address) New City Hospital.15 Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17, 1920

17 I HEREBY CERTIFY, That I attended deceased from
June 7, 1920, to June 17, 1920
that I last saw her alive on June 16, 1920
and that death occurred, on the date stated above, at 8:05 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosisCONTRIBUTORY
(Secondary)(duration) 2 yrs. — mos. — ds.(duration) 5 yrs. — mos. — ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? No special test
(Signed) B. Harrison M. D.19 PLACE OF BURIAL, CREMATION OR REMOVAL New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St Marys Hospital June 19 1920
Chenoweth & Co.

CAUSE OF DEATH in plain terms, so that it can be understood by the layman. See instructions on back of certificates.

JUN 17 1920

D44089

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44089

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

U.S. Marine Hospital

ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Hannes Salminen

(a) RESIDENCE. No.

U.S. Marine Hospital

ST.

WARD.

Unknown

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

1

mos.

2

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

93

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town) (State or country)

Finland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Hospital Record

15

Filed

JUN 17 1920

Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1920

17

I HEREBY CERTIFY, That I attended deceased from May 13, 1920, to June 15, 1920, that I last saw him alive on June 15, 1920, and that death occurred, on the date stated above, at 6:45 p. m. The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 1 yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Don't know

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

19

(Address)

Chas. H. Hage, M. D.
Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn

June 18 1920

20 UNDERTAKER

ADDRESS

Chernowich & Son, Chestnut

CAUSE OF DEATH in plain terms, so that it can be understood by the layman. See instructions on back of certificates.

D44090

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44090

CERTIFICATE OF DEATH.

1-PLACE OF DEATH **Wash. Boulevard & 11th. St.**
 CITY OF BALTIMORE: (No. **Morrell Park.** ST.: **25** WARD) REGISTERED NO. **50**
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME **Mary E. Duckett**
Wash. Boulevard & 11th. St.
 (a) RESIDENCE. NO. **Morrell Park.** ST.: WARD.
 (Usual place of abode)
 Length of residence in city or town where death occurred **56** yrs. mos. ds. How long in U. S., if of foreign birth? **life** yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Female** 4 COLOR OR RACE **White** 5 Single, Married, Widowed, or Divorced (write the word) **Widowed**

5a If married, widowed, or divorced
 HUSBAND of
 (or) WIFE of **James J. Duckett**

6 DATE OF BIRTH (month, day, and year) **June 4, 1844**

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
76 0 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work **None**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) **New York**
 (State or country) **N. Y.**

10 NAME OF FATHER **Lathanel Ruland**

11 BIRTHPLACE OF FATHER (city or town) **Williamsport**
 (State or country) **N. Y.**

12 MAIDEN NAME OF MOTHER **Mary J. Rowe**

13 BIRTHPLACE OF MOTHER (city or town) **Atlantic Ocean.**
 (State or country)

14 Informant **H. F. Duckett**
 (Address) **Union Ave. & Wash. Road.**

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **June 15 1920**

17 I HEREBY CERTIFY, that I attended deceased from **12/18**, 19—, to **June 15**, 19**20**, that I last saw her alive on **June 14**, 19**20**, and that death occurred, on the date stated above, at **1 a.** m.
 The CAUSE OF DEATH* was as follows:

Diabetes

(duration) **2** yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? **no** Date of

Was there an autopsy?

What test confirmed diagnosis?
 (Signed) **Raymond T. Glavin**, M. D.

, 19 (Address) **Lafayette**

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park Cemetery

6/17/20

20 UNDERTAKER

Joseph B. Cook

ADDRESS **1003 N. Ball's Bluff**

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

JUN 17 1920

Burial Permit **Block**

Registrar

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44091

CERTIFICATE OF DEATH

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Grindon Ave* ST. *1* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Louisa Stark*(Residence in Baltimore: No. *Grindon Ave* St.; *68* yrs., *0* mos., *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Widow*

6-DATE OF BIRTH. *Sept 11, 1835*
(Month) (Day) (Year)

7-AGE. *84* yrs., *9* mos., *6* ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *none*
(b) General nature of industry, business, or establishment in which employed (or employer). *abd*

9-BIRTHPLACE, (State or Country). *Germany*

10-NAME OF FATHER. *Geo Stark*
11-BIRTHPLACE OF FATHER (State or Country). *Germany*
12-MAIDEN NAME OF MOTHER. *Margt Plett*
13-BIRTHPLACE OF MOTHER (State or Country). *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Stue D Case*
(Address) *Gardenville*

15-
JUN 18 1920
Burial *Robert E Krauter* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. *June 16, 1920*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from *June 13, 1920*, to *June 16, 1920*, that I saw him alive on *June 16, 1920*, and that death occurred, on the date stated above, at *2:26 p.m.*

The CAUSE OF DEATH* was as follows:
Dropsy, Valvular disease
heart
(Duration) yrs. mos. ds. *10*

CONTRIBUTORY (Secondary) *Skull fracture*
(Signed) *Wm J. Case* M. D.
June 16, 1920 (Address) *Gardenville*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Grindon Park Cem* DATE OF BURIAL, *June 19, 1920*
20-UNDERTAKER, *G. Schloman Son* ADDRESS *1034*

CAUSE OF DEATH
important. See instructions on back of certificate.

REGISTERED NO. C

608 Jasper
Hazel Gray
608 Jasper

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

St.: 1 yrs., 5 mos., 5 ds.

MEDICAL CERTIFICATE OF DEATH.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

1. *June 5th*, *1919*
(Month) (Day) (Year)

If LESS than 1 day.

..... 1 yrs. mon. 10 da.

...hrs. or....min.?

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

D-BIRTHPLACE
(State or Country)

11-BIRTHPLACE
OF FATHER
(State or Country)

12-M AIDEN NAME
JOE MOTHER

13-BIRTHPLACE
OF MOTHER
(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILED

ROBERT E. KRAUTER

101...Burial Permit...Other...

June 16, 1940
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
June 10 1910, to June 16 1910,
that I saw her alive on June 16 1910,
and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

..... (Duration)..... yrs..... mos..... d. 4

CONTRIBUTORY *Exhaustion*.....
(Secondary)

..... (Duration) yrs..... mos. ² d.

(Signed) Frank E. Wagner M. I.

June 15, 1911 (Address) 1076 Edmund

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted,
if not at place of death?.....

Former or
usual residence

10. PLACE OF BURIAL OR REMOVAL.

DATE OF BIRTH

Samuel Bentley

June 18, 1924

20-UNDERTAKES

ADDRESS 776

Daniel Easton Jacobi

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44093

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.: 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Brown

(a) RESIDENCE. No. 513 W. Lee St.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
35				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Jamaica,
(State or country) West Indies

10 NAME OF FATHER Robert Brown

11 BIRTHPLACE OF FATHER (city or town) Jamaica
(State or country) West Indies

12 MAIDEN NAME OF MOTHER Olivia Crosby 6-16-1920

13 BIRTHPLACE OF MOTHER (city or town) Jamaica,
(State or country) West Indies.14 Informant Hospital Records
(Address) New City Hospital.

15 JUN 18 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to June 15, 1920, that I last saw him alive on June 15, 1920, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Cellulitis of Rt. Thigh
General Septicemia
(duration) ten days (2) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? unknown

Did an operation precede death? yes Date of June 3, 1920

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank T. Barber M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Auburn June 19 1920

20 UNDERTAKER ADDRESS 142

John H. Tradin 142

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44094

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Bay View Hospital

CITY OF BALTIMORE: (No.

ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Amelia Lucka

(a) RESIDENCE. NO.

312 Canal

ST. WARD.

(Usual place of abode)

Unknown Life

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female Black

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1856

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

64

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Henry Lucka

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Do.

12 MAIDEN NAME OF MOTHER

Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Bay View Hospital Baltimore, Md.

15

JUN 18 1920

ROBERT I. LAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 16, 1920

17 I HEREBY CERTIFY, That I attended deceased from

May 28, 1920, to June 16, 1920

that I last saw her alive on June 16, 1920, at 4:45 P. M.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Pneumo-Pneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Amile Dementia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys + Mental Exam

(Signed) A. Gledhill M. D.

4/17/20 Address Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Auburn Burial June 19, 1920

20 UNDERTAKER ADDRESS

Samuel S. Samsel 578 W. Baltimore

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44095

CERTIFICATE OF DEATH.

D44095

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Hubbell(a) RESIDENCE. NO. 909 E. Biddle St.

(Usual place of abode)

ST. _____ WARD. _____

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX _____ 4 COLOR OR RACE _____ 5 Single, Married, Widowed, or Divorced (write the word)

Female White Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 18487 AGE Years Months Days If LESS than 1 day, _____ hrs. or _____ min.
72

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland10 NAME OF FATHER James Constance11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Germany12 MAIDEN NAME OF MOTHER Teresa Schlester13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Germany14 Informant Hospital Records
(Address) M. T. H.15 Filed JUN 18 1920 ROBERT L. CHAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15th 192017 I HEREBY CERTIFY, That I attended deceased from June 15th A.M. 1920 to June 15th P.M. 2.0that I last saw her alive on June 15th 19 20.and that death occurred, on the date stated above, at 11.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc(duration) 1 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

anemia (duration) (?) yrs. mos. ds.18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? No Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) George K. Wilbur M. D.6-16-20, 19 20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer's Church June 19 1920

20 UNDERTAKER

ADDRESS

Health Association Hubbell

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44096

CERTIFICATE OF DEATH.

120 D44096

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 Altone Ave. Hamilton ST. 27 WARD)

2-FULL NAME

Royal Lee Phelps

(a) RESIDENCE. (Usual place of abode)

3 Altone Ave. Hamilton ST.

WARD.

Length of residence in city or town where death occurred 2 1/2 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Lillie May Phelps

6 DATE OF BIRTH (month, day, and year)

March 10 1869

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

57

9

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Inspector of Lamp

(b) General nature of industry, business, or establishment in which employed (or employer)

Street Lighting

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Howard County Maryland

10 NAME OF FATHER

William B. Phelps

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Howard Co. Maryland

12 MAIDEN NAME OF MOTHER

Henrietta S. Verna

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Howard Co. Maryland

14

Informant (Address)

Lillie M. Phelps 3 Altone Ave. Hamilton

15

Filed

JUN 18 1920

ROBERT E. EBAUTER Registrar

BRIAL PERMIT 0101

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 16th 1920

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 1, 1916, to June 15, 1920 that I last saw him alive on June 16, 1920

and that death occurred, on the date stated above, at 5:45 P. M.

The CAUSE OF DEATH* was as follows:

Atrial Regurgitation and Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arterio-sclerosis and chronic interstitial nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Chas. E. Smith M. D.

June 17, 1920 (Address) 4706 Hampden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Parkwood Cemetery

June 19 1920

20 UNDERTAKER

ADDRESS

Wm. L. Lissner & Sons

714 S. E. Ave.

Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44097

CERTIFICATE OF DEATH.

28 D44097

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 Princeton Pl ST. 12 WARD)

2-FULL NAME

Herbert E Johnson

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE

No. 311 Princeton Pl

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col. na

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov 4 1899

7 AGE

Years

Months

Days

If LESS than 1 day, — hrs. or min.

20 7 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

nd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Thos H Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

nd

12 MAIDEN NAME OF MOTHER

Phoebe Landrum

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

va

14

Herbert E Johnson

(Address)

311 Princeton Pl

15

Filed JUN 18 1920

ROBERT E. RAUTER Registrar

Burial Permit Grant

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 16 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 10, 1920, to June 15, 1920.

That I last saw him alive on June 14, 1920.

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

General appearance & etc.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? nd

What test confirmed diagnosis? physical

(Signed) Geo H. Hall M. D.

19 (Address) 1126 E 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lamel

June 18, 1920

20 UNDERTAKER

Geo H. Hall

ADDRESS

1631 Alameda Hill an

CAUSE OF DEATH in plain terms, so that it can be understood by the layman. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44098

CERTIFICATE OF DEATH.

103

D44098

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1300 Poplar Grove ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

George Schoenrock

(a) RESIDENCE. NO.

1300 Poplar Grove

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 9 1870

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

49

11

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Unoccupied

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

New York City

10 NAME OF FATHER

Michael Schoenrock

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Volhart

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

William Schoenrock 1300 Poplar Grove

15

Filed

19

ROBERT B. REASTER

Registrar

Burial Permit 07618

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 17 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 17, 1920 to June 17, 1920

that I last saw him alive on June 17, 1920

and that death occurred, on the date stated above, at 3:35 P. M.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Congestion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute Gastritis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Michel M. D.

July 1920 Address 2901 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery June 19 1920

20 UNDERTAKER

ADDRESS

Jos Jourd'heurs Son 217 J. Rte.

CAUSE OF DEATH in plain terms, so that the physician's signature is very important. See instructions on back of certificates.

07618 INDC

D44099

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

80 D44099

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE, 18

yrs. mos. ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed JUN 18 1920

ROBERT E. KRAUTER

BRIAL DEPT. VICE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed)..... M. D.

(Coroner.)

(Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

D44100

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50

D44100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 S. Robinson ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Julia A. Batchlor

(a) RESIDENCE, NO.

411 S. Robinson ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofWidowed

6 DATE OF BIRTH (month, day, and year)

Nov 14 1851

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.6872

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)BaltoMD

10 NAME OF FATHER

John Schaefer

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Sont Kuhn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant
(Address)Ellen Ostrom
411 S. Robinson

15

JUN 18 1920

Burial Form

Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1920

17

I HEREBY CERTIFY, That I attended deceased from

Feb 1, 1919, to June 16, 1920.that I last saw h. ex alive on June 16, 1920.and that death occurred, on the date stated above, at 10 40 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes(duration) 1 yrs. 4 mos. ds.CONTRIBUTORY
(Secondary)Osadenia Lung

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

Clinical(Signed) A. L. Gumbleson, M. D.Address) 2013 Banks

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Carmel CemJune 18 1920

20 UNDERTAKER

J. Herwig & Co

ADDRESS

2008 Orleans

CAUSE OF DEATH in plain terms, as far as possible, on back of certificate. See instructions on back of certificates.

D44101

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44101

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3008 Ellinett*)ST.: *1* WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs Matilda Anna Hart

(a) RESIDENCE. No.

*3008 Ellinett*ST.: *1* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *42* yrs. *10* mos. *20* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

5a If married, widowed, or divorced

(or) WIFE of

Charles B. Hart

6 DATE OF BIRTH (month, day, and year)

July 1878

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42 10 20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Feller Shirt Factory

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Erstange Underwear Co

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

John Thomas Hartmann

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

Mrs Lena Meisel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Washington D.C.

14

Informant (Address)

John Albert Hartmann 4618 Eastern Ave

15

JUN 18 1920

ROBERT F. LEATYER Registrar

Burial permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *6 17 19 20*

17 I HEREBY CERTIFY, That I attended deceased from

*Dec 1, 1919, to June 17, 1920,*that I last saw him alive on *June 16, 1920,*and that death occurred, on the date stated above, at *10 a.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

Labar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Observation

(Signed)

J. B. Sulow

M. D.

17, 1920 Address)

2921 Edmond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Int. Carmel Bern.

DATE OF BURIAL

6/19/ 1920

20 UNDERTAKER

J. A. Moran

ADDRESS

3000 E. Balt St.

CAUSE OF DEATH in plain terms, so that it can be read by anyone. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44103

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *607 Liebert St.* ST.: *16* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Son of George Duallwood + Maggie Jones

(a) RESIDENCE. NO.

607 Liebert St. ST.: *16* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col.

5 Single, Married, Widowed, or Divorced (write the word)

Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Baby

6 DATE OF BIRTH (month, day, and year)

June 18th 1920

7 AGE

Years

Months

Days

If LESS than 1 day, *2* hrs. or *—* min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. City

10 NAME OF FATHER

George Duallwood

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Maggie Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant (Address)

Charles B. Jones 211 N. Pine St.

15

Filed

JUN 18 1920

ROBERT A. KLAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 18th 1920

17

I HEREBY CERTIFY, That I attended deceased from

*June 18th 1920, to June 18th 1920,*that I last saw him alive on *June 18th 1920,*and that death occurred, on the date stated above, at *3. A. M.*

The CAUSE OF DEATH* was as follows:

Premature between 6 and 7 months.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

*Robt. J. Muirhead, M. D.*June 18 1920 (Address) *510 N. Fremont Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Peters Cemetery June 20 1920

20 UNDERTAKER

ADDRESS

Charles B. Jones 211 N. Pine St.

CAUSE OF DEATH IN PARENTS SECTION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44103

CERTIFICATE OF DEATH.

D44103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 334 E. Twentieth

ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Kampmann

(a) RESIDENCE. No. 334 E. Twentieth
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 11 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Casper T. Kampmann

6 DATE OF BIRTH (month, day, and year) June 26, 1849

7 AGE Years 70 Months 11 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER Henry Schultheis

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)14 Informant Miss Louise M. Kampmann
(Address) 334 East 20th. St.15 JUN 18 1920 ROBERT E. KAUTER
Registrar
Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1920

17

I HEREBY CERTIFY, That I attended deceased from May 17, 1920, to June 16, 1920, that I last saw her alive on June 16, 1920, and that death occurred, on the date stated above, at 1:30 P. M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy
(Signed) Harry B. Hodge, M. D.

6/17/1920 (Address) 1101 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Holy Redeemer Cemetery

DATE OF BURIAL

6/19/20 1920

20 UNDERTAKER

Henry W. Mears & Son 805 N. Calvert

ADDRESS

St.

CAUSE OF DEATH in plain language. See instructions on back of certificate.

D44104

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Maryland Penitentiary

ST.

WARD)

REGISTERED NO. C.

2-FULL NAME

William Anderson #2

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

532 N. Vincent St.

St.: 30 yrs., 4 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

Black

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH.

February - 2, 1890

(Month)

(Day)

(Year)

7-AGE.

30 yrs., 4 mos. 13 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Driver

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Robert Anderson

11-BIRTHPLACE OF FATHER
(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or Country),

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Patrick J. Brady

(Address)

Md. Pen.

15-

Robert P. Harrison,

Filed 1920

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 15, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May - 4, 1920, to June - 15, 1920,

that I saw him alive on June - 15, 1920,

and that death occurred, on the date stated above, at 8:25 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation - uremia -

I.D. Peritonitis in 1917.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY Chronic Paronychia

(Secondary) Nephritis

(Duration) ... yrs. ... mos. ... ds.

(Signed) William J. Schwartz M. D.

6/16, 1920 (Address) Md. Penitentiary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 5 yrs. 7 mos. 19 ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Farmer or usual residence 532 Vincent St. Balto. Md.

19-PLACE OF BURIAL OR REMOVAL.

Mt. Auburn Cem.

DATE OF BURIAL 6/19/20; 191...

20-UNDERTAKER

G. B. Pye 102 E. Mulberry.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44105

CERTIFICATE OF DEATH.

D44105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 N. Washington ST.; 8 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 1509 N. Washington St.; 32 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Married

6-DATE OF BIRTH,

Jan 26, 1878
(Month) (Day) (Year)

7-AGE,

42 yrs., 5 mos., 20 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

House Work
037

9-BIRTHPLACE,

(State or Country),

Richmond Va

PARENTS.

10-NAME OF FATHER,

Thomas Wiley

11-BIRTHPLACE OF FATHER

(State or Country),

Richmond Va

12-MAIDEN NAME OF MOTHER

Ellen Owens

13-BIRTHPLACE OF MOTHER

(State or Country),

Richmond Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward H. Hoy(Address) 1509 N. Washington

15-

Robert P. Harrison,Filed 18191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 17, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

5-16- 1920, to 6-17- 1920,that I saw her alive on 6-16 1920and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial
Nephritis(Duration) 3 yrs., mos., ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs., mos., ds.(Signed) M. D.6-17, 1920 (Address) 1509 N. Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cemetery

DATE OF BURIAL,

June 21, 1920

20-UNDERTAKER

Henry Lutz

ADDRESS

1007 N. Bond

CAUSE OF DEATH important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44106

CERTIFICATE OF DEATH.

D44106

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2215 W. Baltimore ST.; 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Wilhemina Lauer(Residence in Baltimore: No. 2215 W. Baltimore St.; 53 yrs., 10 mos., 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married6-DATE OF BIRTH, July 27, 1866
(Month) (Day) (Year)7-AGE, 53 yrs., 10 mos., 20 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. at home
(b) General nature of industry, business, or establishment in which employed (or employer) 1379-BIRTHPLACE, (State or Country), Baltimore Md10-NAME OF FATHER, Henry V. Heller11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER Catherin W. Bing13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adolph B. Lauer(Address) 2215 W. Baltimore St.

15-

JUN 18 1920

Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 17, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Feb 20, 1920, to June 17, 1920, that I saw her alive on June 17, 1920, and that death occurred, on the date stated above, at 10 PM m. The CAUSE OF DEATH* was as follows:
Cardio-Renal Disease
Myocardial Regurgitation
(Duration) 3 yrs., 3 mos., 3 ds.
CONTRIBUTORY Pulmonary Arteriosclerosis
(Secondary) (Duration) 3 yrs., 3 mos., 3 ds.
(Signed) W. S. Lauer M. D.
June 18, 1920 (Address) 836 W. North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Landon Park Cemetery June 19, 1920

20-UNDERTAKER, ADDRESS

Geo. H. Luebig 2001 W. Baltimore St.

important. See instructions on back of certificate.

D44107

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44107

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Aged Women Home* St.; *19* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1400 W. Lexington* St.; *30* yrs., *30* mos., *30* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*

6-DATE OF BIRTH,

Oct 22

(Month)

(Day)

1888
(Year)

7-AGE,

81 yrs., *9* mos., *15* ds.

If LESS than 1 day,

...hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*None*

9-BIRTHPLACE, (State or Country),

Falbot Co. Md.

10-NAME OF FATHER,

W. L. Jones

11-BIRTHPLACE OF FATHER

(State or Country),

Falbot Co. Md.
Royal Oak

12-MAIDEN NAME OF MOTHER

Sarah A. Tyler

13-BIRTHPLACE OF MOTHER

(State or Country),

Dorchester Co. Md.
Golden Hill

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ellie J. Jones

(Address)

W. L. Jones

15-

Robert P. Harrison,

Filed

191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 18, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1917 to *June 18, 1920*that I saw h. alive on *June 17, 1920*and that death occurred, on the date stated above, at *7 A.* m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart(Duration) *1* yrs., *30* mos., *30* ds.

CONTRIBUTORY (Secondary)

Feeling ill

(Signed)

J. J. Jones M. D.*June 18, 1920* (Address) *739 W. Fayette*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *15* yrs., *30* mos., *30* ds. In the *30* yrs., *30* mos., *30* ds. State

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Roundon Park**June 21, 1920*

20-UNDERTAKER

ADDRESS

*George J. Smith**1000 W. Fayette*

CAUSE OF DEATH in part on back of certificate. important. See instructions on back of certificate.

JUN 18 1920

D44108

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO *Johns Hopkins* ST.: *72* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennery M. Beard

(a) RESIDENCE. No 11214 Mens/Stone Rd ST.
(Usual place of abode)

WARD. *Chesterfield Mass*
(If nonresident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

3 SEX Female	4 COLOR OR RACE white	5 Single, Married, Widowed, or Divorced (write the word) Widowed.
-----------------	--------------------------	---

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of *Julian M. Beard*

6 DATE OF BIRTH (month, day, and year) *Dec. 11, 1859*

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	60	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housekeeper*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town).....
(State or country) USA ✓ 7/1 ✓

10 NAME OF FATHER *Eli. P. Phelps*

11 BIRTHPLACE OF FATHER (city or town)
(State or country) *1/2*

12 MAIDEN NAME OF MOTHER *Mary Bennett.*

13 BIRTHPLACE OF MOTHER (city or town).....
(State or country) USA

14 Informant Henry Webb Gallman
(Address) 7 S. Clinton St. Baltimore

15 Filed Robert P. Harrison Registrar

16 DATE OF DEATH (month, day, and year) *June 17* 1920

16 DATE OF DEATH (month, day, and year) June 17 1920

17 I HEREBY CERTIFY, That I attended deceased from
May 14, 1920, to June 17, 1920,
that I last saw her alive on June 17, 1920,
and that death occurred, on the date stated above, at 12:00 a.m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma to the Spine
 & paralysis from the waist down.

..... (duration) yrs. **4** mos. da

CONTRIBUTORY *Owner of the Boat.*
(Secondary) *7* (duration) *7* yrs. *7* mos. *7* ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) M. D.

, 19 (Address) Johns Hopkins Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL

Anne Brunel Co. Md. June 19 194

[illegible]

Mr C. Black 927 N. Broadway

CAUSE OF DEATH in plain terms, so that the physician's certification is very important. See instructions on back of certificates.

Filed _____
JUN 18 1920

Burial Permit Clerk,

D44109

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44109

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

510 N. Linwood Ave. 7

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Albina Wimmer

(a) RESIDENCE. NO.

510 N. Linwood Ave.

WARD.

Length of residence in city or town where death occurred

29 yrs. 3 mos. 17 ds.

How long in U. S., if of foreign birth? 29 yrs. 3 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

1 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND or (or) WIFE of

Charles Wimmer

6 DATE OF BIRTH (month, day, and year)

3. 11. 63.

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Austria

10 NAME OF FATHER

Michael Schettle

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Austria

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Austria

14

Informant (Address)

Charles Wimmer
510 N. Linwood Ave.

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6. 17. 19 20

I HEREBY CERTIFY, that I attended deceased from June 17, 19 20, to June 17, 19 20.

that I last saw him alive on June 17, 19 20,

and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy
Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test completed diagnosis?

(Signed) Charles W. A. Meyer, M. D.

18, 19 20 Address 1031 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

June 21 19 20

20 UNDERTAKER

ADDRESS

Wendell Rappell & Son

37 S. M.

CAUSE OF DEATH IN PHRASES, as far as possible, should be stated in full on back of certificate. See instructions on back of certificates.

JUN 18 1920

D44110

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D44110

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2438 E Preston

ST.:

WARD)

2-FULL NAME

James H White

(a) RESIDENCE. No.

2438 E Preston

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

70

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

70

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed,
or Divorced (write the word)

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Eliza White

6 DATE OF BIRTH (month, day, and year)

January 8 1841

7 AGE

Years

Months

Days

If LESS than

day, hrs.

or min.

79

5

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Carpenter

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Accomac County Va

10 NAME OF FATHER

Wm H White

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Accomac County Va

12 MAIDEN NAME OF MOTHER

Elizabeth Bayley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Accomac County Va

14

Informant
(Address)

Lee M White

2438 E Preston

15

Filed

19 Robert P. Harrison,

Registrar

Burial Permit Clerk.

REGISTERED No.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

ST.:

WARD)

ST.

WARD.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 17 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 10, 1920, to June 17, 1920,

that I last saw him alive on June 17, 1920,

and that death occurred, on the date stated above, at 9:38 a. m.

The CAUSE OF DEATH* was as follows:

Pulver Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY
(Secondary)

No contributory

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Peripneumonia

(Signed) J. E. Hedges, M. D.

June 17, 1920 (Address) 1301 N Pat Park

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park

July 19 1920

20 UNDERTAKER

ADDRESS

Nendell Lippel & Son

37 N Mm

CAUSE OF DEATH in plain terms, so that it may be understood by the public. See instructions on back of certificates.

JUN 18 1920

D44111

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44111

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2956 Prestman ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2956 Prestman St.; 40 yrs., — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

White.

5-SINGLE,
MARRIED, ☒
WIDOWED, ☒
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

Dec 3, 1860
(Month) (Day) (Year)

7-AGE,

59 yrs. 6 mos. 15 ds.

If LESS than 1 day,

— hrs. or — min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Jimm. Keefm. Hotel
Clerical.9-BIRTHPLACE,
(State or Country),

Baltimore Co.

10-NAME OF FATHER,

Henry Merryman

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore Co.

12-MAIDEN NAME OF MOTHER

Unknown.

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry M. Erickson(Address) 2956 Prestman St.

15-

Robert P. Harrison,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 18, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from June 16, 1920, to June 18, 1920, that I saw him alive on June 17, 1920, and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

apoplexy.

(Duration) — yrs. — mos. — ds.

CONTRIBUTORY
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) H. O. Grant M. D.June 18, 1920 (Address) 1207 Poplar St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Olivet

DATE OF BURIAL,

June 21, 1920

20-UNDERTAKER

See W. Little

ADDRESS

531 St. Fremont

CAUSE OF DEATH in pink box important. See instructions on back of certificate.

JUN 18 1920

D44112

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44112

CERTIFICATE OF DEATH.

* 30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST.: *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sadie Bennett

(a) RESIDENCE. NO.

108 Maine St Farmville N.C.

WARD.

Farmville N.C.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Nov-1906

7 AGE

13

Years

Months

Days

If LESS than 1 day, hrs. or min.

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

N. C.

10 NAME OF FATHER

James Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N. C.

12 MAIDEN NAME OF MOTHER

Mollie Vine

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N. C.

14

Informant (Address)

Hospital Record J. H. H.

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 16 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*June 9, 1920 to June 16, 1920*that I last saw him alive on *June 16, 1920*and that death occurred, on the date stated above, at *6:50 P. M.*

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis(duration) yrs. mos. *21* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *None*(Signed) *V. R. Mason*, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Farmville N.C.**June 18 1920*

20 UNDERTAKER

ADDRESS

H. E. Hughes - 17 S. Bay

CAUSE OF DEATH in plain terms, so that it can be understood by the layman. See instructions on back of certificates.

JUN 18 1920

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44113

D44113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 Orlean ST.; 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1619 Orlean st St.; 15 yrs., 15 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M4-COLOR OR RACE, Colored5-SINGLE, Widowed
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, unborn, 1875

(Month)

(Day)

(Year)

7-AGE, 45yrs. 1 mos. 1 ds.

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Laborer
(b) General nature of industry, business, or establishment in which employed (or employer), 0409-BIRTHPLACE, (State or Country), Fla10-NAME OF FATHER, not known11-BIRTHPLACE OF FATHER (State or Country), not known12-MAIDEN NAME OF MOTHER, not known13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kellie Dryers(Address) 1619 Orlean st

15-

Filed

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16th, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20 1920, to June 16 1920, that I saw him alive on June 16 1920, and that death occurred, on the date stated above, at 11 A m. The CAUSE OF DEATH* was as follows:Pulmonary Tuberculosis
(Duration) 4 yrs. 4 mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) 4 yrs. 4 mos. 1 ds.(Signed) Harry T. Brown

M. D.

June 16, 1920 (Address) 1501 Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 15 yrs. 15 mos. 15 ds. In the State 15 yrs. 15 mos. 15 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, LaurelDATE OF BURIAL, June 29, 192020-UNDERTAKER, John W. HendersonADDRESS 1502 E Monument

CAUSE OF DEATH in plain terms, important. See instructions on back of certificate.

JUN 19 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44114

D44114

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 Peach al ST. 17 WARD)

2-FULL NAME

Residence in Baltimore: No. 807 Peach al St. Life yrs., 0 mos., 0 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

col.5-SINGLE, in
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Dec. 15, 1919
(Month) (Day) (Year)

7-AGE,

6 yrs., 0 mos., 0 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....none
(b) General nature of industry, business, or establishment in which employed (or employer).....0009-BIRTHPLACE,
(State or Country),md

10-NAME OF FATHER,

Walter Gant11-BIRTHPLACE OF FATHER
(State or Country),md

12-MAIDEN NAME OF MOTHER

Gladys Davis13-BIRTHPLACE OF MOTHER
(State or Country),md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Gladys Gant(Address).....807 Peach al

15-

Robert P. Harrison.....

191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 15, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 15 1920, to June 15 1920, that I saw her alive on June 17 1920, and that death occurred, on the date stated above, at 12:30 m.
The CAUSE OF DEATH* was as follows:Acute Gastro-Enteritis..... (Duration)..... yrs..... mos. 5 ds.
CONTRIBUTORY (Secondary) Infantile Convulsion(Signed).....W. H. Harrison M. D.
6/15/20, 1920 (Address) 140 W. Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

St. Auburn

DATE OF BURIAL,

June 19, 1920

ADDRESS

20-UNDERTAKER

W. H. Brown "Son" 108 W. Montg

Important. See instructions on back of certificate.

D44115

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44115

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 W. Hill ST.; 22 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 213 W. Hill St.; 22 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fe. 4-COLOR OR RACE, Col. 5-SINGLE, MARRIED, Married, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, June 10th, 1879
(Month) (Day) (Year)7-AGE, 41 yrs. 0 mos. 6 ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housewife
(b) General nature of industry, business, or establishment in which employed (or employer), 0379-BIRTHPLACE, (State or Country), Va.10-NAME OF FATHER, Henry Perkins11-BIRTHPLACE OF FATHER (State or Country), Va.12-MAIDEN NAME OF MOTHER Caroline ?13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. Felton(Address) 213 W. Hill St.

15-

JUN 19 1920 Robert L. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16th, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 2 1920, to June 16 1920, that I saw her alive on June 16 1920, and that death occurred, on the date stated above, at 9:30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis
(Duration) Several months yrs. mos. ds.CONTRIBUTORY (Secondary) Tuberculosis
(Duration) 28 yrs. mos. ds.(Signed) J. H. Harrison M. D.
6/18, 1920 (Address) 140 W. Hill St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn Ct

DATE OF BURIAL,

June 20, 1920

20-UNDERTAKER

J. H. Brown & Son

ADDRESS

10 W. Montg.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44116

D44116

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2008 N. Zonvale* ST. *16* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2008 N. Zonvale* St.; *65* yrs., *3* mos. *30* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH.

Feb 17 *1885*
(Month) (Day) (Year)

7-AGE,

65 yrs., *3* mos. *30* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Cape Hanger*
052

9-BIRTHPLACE.

(State or Country).

Balto City Md

10-NAME OF FATHER.

John Henry Fortling

11-BIRTHPLACE OF FATHER.

(State or Country).

Md

12-MAIDEN NAME OF MOTHER.

Sarah Gittier

13-BIRTHPLACE OF MOTHER.

(State or Country).

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Ella Fortling
2008 N. Zonvale
(Address)

15-

Robert *191*
Filed *1920* Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 16, *1920*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *abt May 1* 1920, to *June 17* 1920,that I saw him alive on *June 17* 1920,and that death occurred, on the date stated above, at *340 B.* m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever
abt 6 weeks
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)(Signed) *Edw B. Rider* M. D.*June 18*, 1920 (Address) *867 Haslam Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL.

Lorraine Cemetery *June 19*, 1920

20-UNDERSEALER

ADDRESS

Er. Ribur, Son *2503 E. North*
ave

CAUSE OF DEATH in plain terms important. See instructions on back of certificate.

D44117

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44117

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1514 N Madeira* ST.; *8* WARD)

REGISTERED NO. C

2-FULL NAME *Jennie Gala*(Residence in Baltimore: No. *1514 N Madeira* St.; *life* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *female*4-COLOR OR RACE *white*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH, *April 10, 1920*

(Month)

(Day)

(Year)

7-AGE, *X* yrs. *2* mos. *8* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *X*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Balto Maryland*10-NAME OF FATHER, *Antonio Gala*11-BIRTHPLACE OF FATHER (State or Country), *Cuba*12-MAIDEN NAME OF MOTHER *Maria Lora*13-BIRTHPLACE OF MOTHER (State or Country), *Cuba*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Antonio Gala*(Address) *1514 N Madeira*

15-

Robert P. Harrison,

Filed *June 19 1920*

191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *June 18, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *JUN 15 1920* 191, to *JUN 18 1920* 191, that I saw hER alive on *JUN 18 1920* 191, and that death occurred, on the date stated above, at *8¹⁵ p m.*

The CAUSE OF DEATH* was as follows:

Convulsion possibly Meningitis(Duration) *X* yrs. *X* mos. *1* ds.CONTRIBUTORY (Secondary) *Acute Gastro Intes.**tinal Colic* (Duration) *X* yrs. *X* mos. *4* ds.(Signed) *J. H. Dyer* M. D.*JUN 18 1920* (Address) *928 N. North*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cemetery*DATE OF BURIAL, *June 19, 1920*20-UNDERTAKER *Henry Lutz*ADDRESS *1007 N. Bond*

important. See instructions on back of certificate.

D44118

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D44118
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *903 Warner St.* ST.; *21* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *903 Warner St.* St. *21* yrs. *7* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *col* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
 6-DATE OF BIRTH, *September 15, 1897*
 (Month) (Day) (Year)

7-AGE, *29* yrs. *9* mos. *1* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work, *023*
 (b) General nature of industry, business, or establishment in which employed (or employer), *Driver*

9-BIRTHPLACE, (State or Country), *Ind*

10-NAME OF FATHER, *James B. Brooks*

11-BIRTHPLACE OF FATHER (State or Country), *Ind*

12-MAIDEN NAME OF MOTHER, *unmarried*

13-BIRTHPLACE OF MOTHER (State or Country), *Cambridge*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James Brooks*

(Address) *903 Warner St.*

15-*1919* Robert P. Harrison, Registrar.

Filed *1919* Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 16, 1912*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 16, 1912*, to *June 16, 1912*, that I saw him alive on *June 15, 1912*, and that death occurred, on the date stated above, at *8574* m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemiplegic

(Duration) yrs. *3* mos. *16* ds.

CONTRIBUTORY (Secondary) *Heart Disease*

(Duration) yrs. *3* mos. *16* ds.

(Signed) *J. H. Howard* M. D.

June 17, 1912 (Address) *712 S. Harper St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Anturn Cemetery* DATE OF BURIAL, *6/20/12, 1912*

20-UNDERTAKER, *Mrs. S. H. Cooper* ADDRESS, *406 W. Carey St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44119

CERTIFICATE OF DEATH.

50 D44119
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital 28* ST.; WARD)

2-FULL NAME

(Residence in Baltimore: No. *4103 Ferrell Ave* St.; *3* yrs., *3* mos. *3* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Married

6-DATE OF BIRTH,

Sept 10, 1860
(Month) (Day) (Year)

7-AGE.

59 yrs. *9* mos. *8* da. If LESS than 1 day, *hrs.* or *min.*

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).
*Retired*9-BIRTHPLACE,
(State or Country),*U.S.A. Va.*

10-NAME OF FATHER,

*Henry L. Blount*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Schmidt-Hoffman*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Mary Blount*(Address) *4103 Ferrell Ave*

15-

*Robert P. Harrison,*Filed *10-19-20*

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 18, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*May 17, 1920, to June 18, 1920,*that I saw him alive on *June 18, 1920,*and that death occurred, on the date stated above, at *7:50 a.m.*

The CAUSE OF DEATH* was as follows:

Coma Diabetic
Cardiac Failure

(Duration).....yrs.....mos.....da.

CONTRIBUTORY

Diabetic - long (Duration).....yrs.....mos.....da.(Signed) *Louis Sachs* M. D.*June 18, 1920* (Address) *The Hebrew Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *0* yrs. *0* mos. *29* da. In the State.....yrs.....mos.....da.Where was disease contracted, if not at place of death? *At ??*Former or usual residence *4103 Ferrell Ave*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Beth Yehon *June 20, 1920*

20-UNDERTAKER ADDRESS

David Goldheim *118 W. Myrtle Ave*

D44120

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

D44120

PLACE OF DEATH

CITY OF BALTIMORE (No.

ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St. 56 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

married

6-DATE OF BIRTH

Sep 15, 1864

7-AGE

55 yrs. 4 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Clerk

9-BIRTHPLACE
(State or country)

Germany

10-NAME OF FATHER

Ludwig Korgel

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Elizabeth Kerschholz

13-BIRTHPLACE OF MOTHER
(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Korgel

(Address)

1710 Johnson St.

15

Robert P. Harrison,

191

REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 16, 1920
(Month) June (Day) 16 (Year) 1920

17. I HEREBY CERTIFY, That I attended deceased from

May, 1919, to, June, 1920

that I saw him alive on June 15, 1920

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)

Syphilis

(Duration) yrs. mos. ds.

(Signed)

G. E. 3 Thoms M. D.

June 18, 1920 (Address) 210 W. Madison

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Grave Hill

DATE OF BURIAL

June 19, 1920

20-UNDERTAKER

Ed Manning 1938 E Lafayette

N. B.—Every item of information should be entered in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

JUN 19 1920

D44121

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 31

D44121

1-PLACE OF DEATH

CITY OF BALTIMORE:

No. 1512 W Fairmount

ST.:

19

WARD)

2-FULL NAME

Rosa Corbett

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

1512 W. Fairmount

ST.

WARD.

Florida

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

2 mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Louisville Ky

10 NAME OF FATHER

John Kennedy

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

don't know

12 MAIDEN NAME OF MOTHER

don't know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Don't know

14

Informant
(Address)Charles Corbett
1512 W. Fairmount

15

Filed

JUN 20 1920

ROBERT S. FAUTER

Registrar

Burial

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-18-1920

17

I HEREBY CERTIFY, That I attended deceased from

June 10, 1920, to June 18, 1920,

that I last saw him alive on June 16, 1920,

and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis

(duration) yrs. 1? mos. ds.

CONTRIBUTORY
(Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard J. French, M. D.

6/18, 1920 (Address) 1707 E. Enoch Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Cem

June 20 1920

20 UNDERTAKER

ADDRESS

A. Jones

207 S. Street

CAUSE OF DEATH in plain terms, as stated on back of certificates. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44122

CERTIFICATE OF DEATH.

REGISTERED NO.

D44122

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 S. Hollington Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Kazmiera Daniecka

(a) RESIDENCE. NO.

509 S. Hollington Ave ST.: 1 WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Feb 16-1919

7 AGE

Years

Months

Days

If LESS than 1 day, — hrs. or — min.

1

4

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Jacob Daniecka

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland Russia

12 MAIDEN NAME OF MOTHER

Helen Kieniska

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland Russia

14

Informant

(Address)

Jacob Daniecki

509 S. Hollington Ave

15

Filed

JUN 20 1920

BORIS S. REUTER

Boris S. Reuter

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 19 1920

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1920, to June 19, 1920, that I last saw her alive on June 17, 1920, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Gastric Enteritis

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. 7 mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) A. P. Reuter, M. D.

, 19 (Address) 408 S. Pratt Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Rosary Cemetery June 20 1920

20 UNDERTAKER ADDRESS

Stephen Flakowski

CAUSE OF DEATH IN PARENTS TION is very important. See instructions on back of certificates.

D44123

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

REGISTERED NO. C

D44123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 Aisquith St St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hinda Sacks(Residence in Baltimore: No. 712 Aisquith Street St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

Urban, 1 (Month) (Day) (Year)

7-AGE,

72 yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country),

Russia

10-NAME OF FATHER,

Hyman

11-BIRTHPLACE OF FATHER, (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Urban

13-BIRTHPLACE OF MOTHER, (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

J. Lewis

(Address),

1411 E. Baltimore St.

15-

Filed

JUN 20 1920

ROBERT E. KRAUTER

BRIAL PAPER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

6 20, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Oct 1919, to June 19 1920,that I saw her alive on June 19 1920, and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
(Duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.(Signed) A. G. Hornstein M. D.4/20/20, 191... (Address) 733 Aisquith St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

Greenwood6-20-20, 19120

20-UNDERTAKER

ADDRESS

John Lewis, 1411 E. Baltimore St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44124

CERTIFICATE OF DEATH.

79 D44124
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2605 Roslyn Ave 16 ST. WARD)

2-FULL NAME May E. Bennett

(a) RESIDENCE. NO. 2605 Roslyn Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 4 mos. ds.

How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

Female White Married

5a If married, widowed, or divorced

(or) WIFE of

Guy E. Bennett

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

33

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed

JUN 20 1920

ROBERT E. KRAUTER

Registrar

BIRTH PLACE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

June 20th, 1920, to June 20th, 1920.

that I last saw her alive on June 18th, 1920.

and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis and
Vascular Lesions

(duration) 5 yrs. mos. ds.

CONTRIBUTORY Secondary Dilatation
(Secondary)

(duration) 5 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William H. Messick, M. D.

, 19 (Address) 1700 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Brooklyn N.Y. June 21, 1920

20 UNDERTAKER

ADDRESS

Graham T. Walker 7230 Rd

D44125

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1334 Argyle av

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Louisa F. Chisley

(Residence in Baltimore: No.

1334 Argyle av

St.; 48 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
4-COLOR OR RACE, Colored
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widowed (Write the word.)
6-DATE OF BIRTH, Sept 5th, 1869 (Month) (Day) (Year)

7-AGE, 50 yrs. 2 mos. 16 ds. If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housewife
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Eastern Shore Md.

10-NAME OF FATHER, Louis Farrell
11-BIRTHPLACE OF FATHER (State or Country), Not Known
12-MAIDEN NAME OF MOTHER, Not Known
13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Lewis Albert Chisley
(Address), 1334 Argyle av

15-

Filed JUN 20 1920 ROBERT A. Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 18th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 6 - 1920, to June 18th 1920, that I saw her alive on June 17th 1920, and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows: acute myocarditis - with paraplegia and paralysis of bladder and rectum.

(Duration)yrs.mos.ds.

CONTRIBUTORY (Secondary)

(Duration)yrs.mos.ds.

(Signed) Chas. J. Keeler, M. D.

June 18, 1920 (Address) 222 W. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

St. Paul's Church

6/21/20, 191...

20-UNDERWRITER

ADDRESS

W. B. Pye

102 E. Mulberry

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44126

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 1/2 Calhoun ST.; 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 1315 1/2 Calhoun ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

JUN 20 1920

ROBERT F. LEAUTEN

Registrar

Burial Permit 01224

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

June 15", 1920, to June 18", 1920,

that I last saw him alive on June 18", 1920,

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Hypertrophy of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) A. B. Glascock, M. D.

, 19 (Address) 1110 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44127

CERTIFICATE OF DEATH.

131 ✓ D44127
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 Myrtle Court St. 11 WARD)2-FULL NAME Sarah M. Tyeleman

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1103 Myrtle Court St.; 10 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female4-COLOR OR RACE. Caucasian5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH. July 1847

(Month)

(Day)

(Year)

7-AGE. 72

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 0709-BIRTHPLACE, (State or Country), MD

PARENTS.

10-NAME OF FATHER, Joe Tibson11-BIRTHPLACE OF FATHER (State or Country), MD12-MAIDEN NAME OF MOTHER unmarried13-BIRTHPLACE OF MOTHER (State or Country), MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Tyeleman(Address) 1103 Myrtle Court

15-

Filed JUN 20 1920

191

ROBERT E. KAUTER

BRIAL PARENT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 17th, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1920 to June 17 1920that I saw him alive on June 17 1920and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

General Peritonitis(Duration) 3 yrs., 0 mos., 0 ds.CONTRIBUTORY (Secondary) Alcoholism(Duration) 10 yrs., 0 mos., 0 ds.(Signed) A. R. H. M. D.6719, 191 (Address) 724 Myrtle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

St. Anthony June 21, 192020-UNDERTAKER Carroll Wright ADDRESS 1364 McCom

D44128

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44128

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *119 S Carey* ST.; *18* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Margaret Humbro*(Residence in Baltimore: No. *119 S. Carey* St.; *60* yrs., *0* mos., *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *7*4-COLOR OR RACE, *W.*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED
(Write the word.) *Widow*6-DATE OF BIRTH, *1853*

(Month)

(Day)

(Year)

7-AGE, *67*

yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Wife*(b) General nature of industry, business, or establishment in which employed (or employer) *000*9-BIRTHPLACE, (State or Country), *Ireland*10-NAME OF FATHER, *Unknown*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Philly Sibival*(Address) *119 S. Carey St*

15-

Filed *JUN 20 1920*

191

ROBERT B. KRAUTH

BRYANT T. TAYLOR

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 18, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Feb.* *1920*, to *June 18 1920*,that I saw him alive on *June 17 1920*,and that death occurred, on the date stated above, at *12:30* m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach(Duration) *1* yrs. mos. ds.CONTRIBUTORY *Auto Intoxication*
(Secondary)(Duration) *7* yrs. mos. ds.(Signed) *Edward Nevolabian* M. D.*June 19, 1920* (Address) *24 N. Fullin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *0* yrs. mos. ds. In the *0* yrs. mos. ds. State *0* yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park*DATE OF BURIAL, *June 20, 1920*20-UNDERTAKER *AS Marshall 3539 Fall Rd*

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44130

CERTIFICATE OF DEATH.

170 ✓ D44130
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3543 Roland Ave. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Thornton Toomey

(a) RESIDENCE. No. 3543 Roland Ave. ST. 13 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Rebecca Toomey

6 DATE OF BIRTH (month, day, and year) July 22-1838

7 AGE Years 81 Months 10 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster Penna.

10 NAME OF FATHER Daniel Toomey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Mary Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Charles P. Storey
(Address) 3543 Roland Ave.15 JUN 20 1920 ROBERT E. LEAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1918, to June 18, 1920, that I last saw him alive on June 18, 1920, and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Inter Nephritis

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted If not at place of death? unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. McQuinn, M. D.
1920. 1920 Address 846 W 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park June 21 1920

20 UNDERTAKER ADDRESS

Forace Burgee Son 363 Fulton Rd

CAUSE OF DEATH IS VERY IMPORTANT. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44131

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1436 John St. ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Daniel Larrabee

(a) RESIDENCE

No. 1436 John St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 78 yrs. 11 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

Late Janet Larrabee

6 DATE OF BIRTH (month, day, and year)

June 21, 1841

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

78

11

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired Dry Goods Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Edward H. Larrabee

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Eliza Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Stewart Larrabee 1436 John St.

15

File

ROBERT A. ERAUTER Registrar

Baptist Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 19, 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 10, 1917, to June 18, 1920

that I last saw him alive on June 18, 1920

and that death occurred, on the date stated above, at 6:10 A. M.

The CAUSE OF DEATH* was as follows:

arterio sclerosis

CONTRIBUTORY (Secondary)

(duration) 3 yrs. mos. ds.

(duration) 21 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. J. E. H. M. D.

6/14, 1920 (Address) 2042 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Druid Ridge Cemetery June 21, 1920

20 UNDERTAKER

ADDRESS

Henry H. Jenkins & Sons 60 N. Holladay St.

CAUSE OF DEATH IN PARTIAL VIEW OF INSTRUCTIONS ON BACK OF CERTIFICATES. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D44132

1-PLACE OF DEATH

CITY OF BALTIMORE, No.

2-FULL NAME

(a) RESIDENCE, No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

75 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

JUN 20 1920

ROBERT H. KLAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1920

17

I HEREBY CERTIFY, That I attended deceased from

6/19, 1920, to 6/20, 1920,

that I last saw him alive on 6/20, 1920,

and that death occurred, on the date stated above, at 2:00 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Neph.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

20, 1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Airy Cem. June 21 1920

20 UNDERTAKER

ADDRESS

H. Jenkins & Sons Co. No. 1000 N. E. St.

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

Ida Moller
HEALTH DEPARTMENT—CITY OF BALTIMORE

D44133

CERTIFICATE OF DEATH.

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1200 S. Charles* ST.: *23* WARD)2-FULL NAME *Ida Moller*(a) RESIDENCE. No. *1200 S. Charles* ST.: *24* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct 10, 1901*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
18 *8* *8*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Clerk*(b) General nature of industry, business, or establishment in which employed (or employer) *Music Store*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*
(State or country)10 NAME OF FATHER *Anthony Moller*11 BIRTHPLACE OF FATHER (city or town) *Baltimore*
(State or country)12 MAIDEN NAME OF MOTHER *Emma Moller*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore*
(State or country)14 Informant *Dora Danner*
(Address) *1217 Charles St.*15 Filed *JUN 20 1920* *ROBERT E. KRAUTER* Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 18, 1920*

17 I HEREBY CERTIFY, That I attended deceased from *June 15, 1920*, to *June 18, 1920*, that I last saw him alive on *June 18, 1920*, and that death occurred, on the date stated above, at *4:30 P.M.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORS (duration) yrs. mos. ds.
Robert Strauss *3* *0* *0*
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *out doors*

Did an operation precede death? Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *W. H. Harrison* M. D., 19 (Address) *131 E. 14th St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Con.
20 UNDERTAKER *W. A. Trause & Son*

June 20 1920
ADDRESS *703 Reisterstown Rd.*

CAUSE OF DEATH—See instructions on back of certificates. See instructions on back of certificates. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44134

CERTIFICATE OF DEATH.

REGISTERED NO.

D44134

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

302 S. Highland Ave. 26 ST. WARD)

2-FULL NAME

Louisa M. Frank

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

302 S. Highland

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

48 yrs.

4 mos.

15 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

WIFE of

John C. Frank

6 DATE OF BIRTH

(month, day, and year)

Feb. 2-1872

7 AGE

Years

Months

Days

If LESS than 1 day, - hrs. or - min.

48

4

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Co. Md.

10 NAME OF FATHER

Adam Sohn

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany.

12 MAIDEN NAME OF MOTHER

Anna Coester

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany.

14

Informant (Address)

John C. Frank.
302 S. Highland Ave.

15

Date

JUN 20 1920

ROBERT E. LAUTER

Registrar

Burial Permit 0122

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 17 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 19 1920

June 17 1920

that I last saw him alive on June 17 1920

and that death occurred, on the date stated above, at 11.50 P. M.

The CAUSE OF DEATH* was as follows:

Purpura Acutissima

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) Edward H. London M. D.

19 (Address) 750 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oaklawn Cemetery

June 21 1920

20 UNDERTAKER

Zirkler + Zirkler

ADDRESS

1789 E. Egan St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44135

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1529 N. Mount ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1529 N. Mount St.; 35 yrs., 3 mos., 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 15, 1861
(Month) (Day) (Year)

7-AGE, 59 yrs., 3 mos., 3 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Gardner
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Danville, Va.

10-NAME OF FATHER, X unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER, X unknown

13-BIRTHPLACE OF MOTHER (State or Country), X unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Love
(Address) 1529 N. Mount St.

15- JUN 20 1920 ROBERT E. EAUTER
Filed.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 22, 1920, to June 19, 1920, that I saw him alive on June 18, 1920, and that death occurred, on the date stated above, at 2 A. m.
The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease
(Duration).....yrs. 3 mos.....ds.

CONTRIBUTORY (Secondary).....
(Duration).....yrs.....mos.....ds.
(Signed) John D. Quinn, M. D.
June 19, 1920 (Address) 1507 N. Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, MT Auburn DATE OF BURIAL, June 22, 1920

20-UNDERTAKER, Eduw Ringgold ADDRESS 1403 Carey

important. See instructions on back of certificate.

D44136

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FED.

191

ROBERT B. KRAUTER

BRIAN PATRICK

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

(Coroner.)

JUN 18, 1920 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place In the
of death.... yrs.... mos.... ds. State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44137

CERTIFICATE OF DEATH.

28 ✓ D44137
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4258 Chester ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 4258 Chester St.; 40 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Mar 2, 1864
(Month) (Day) (Year)

7-AGE, 56 yrs., 3 mos., 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) State Department

9-BIRTHPLACE, (State or Country), Ireland

10-NAME OF FATHER, John Foley

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ellen Mc Donough

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Foley(Address) 204 S. Washington

JUN 20 1920

ROBERT E. KRAUTER

Filed..... 191.....

BALTIMORE REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 13 1918, to June 16 1920, that I saw him alive on June 16 1920, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) 2 yrs., mos., ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis
(Duration) 3 yrs., mos., ds.

(Signed) Geo. Heller M. D.6-20, 1920 (Address) 1937 Gough

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Hof Cross Cemetery 6/21, 1920

20-UNDERTAKER ADDRESS 3000

J. J. Moran & B. B. B. B.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Jules Hopkins Hospital* ST.; *3rd* WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

*Married*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Wife of Quinn*

6 DATE OF BIRTH (month, day, and year)

Feb. 17 - 1870

7 AGE

Years

Months

Days

If LESS than
1 day, ____ hrs.
or ____ min.*50**3**3*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Factory - work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Ireland*

10 NAME OF FATHER

*Quinn?*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Ireland*

12 MAIDEN NAME OF MOTHER

*Annie Donnelly*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Ireland*

14

Informant
(Address)*J. H. Peters*

15

*JUN 21 1920*ROBERT R. FRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 18 1920

17

I HEREBY CERTIFY, That I attended deceased from

*June 1st 1920, to June 18, 1920*that I last saw her alive on *June 18, 1920*and that death occurred, on the date stated above, at *3:25 P. M.*

The CAUSE OF DEATH* was as follows:

*Uterine Weri - Chronic Salpingitis,
Subacute Appendicitis - &*(duration) - yrs. *3* mos. - ds.

CONTRIBUTORY

(Secondary)

*Intestinal Perforation, &
General Peritonitis* (duration) - yrs. - mos. *15* ds.18 Where was disease contracted
if not at place of death?*NOT KNOWN -*Did an operation precede death? *Yes* Date of *June 2, 1920*Was there an autopsy? *Yes*What test confirmed diagnosis? *Yes*(Signed) *Laurence R. Wharton*, M. D., 19 (Address) *Jules Hopkins Hospital &*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mount Carmel Cemetery**6/21 1920*

20 UNDERTAKER

ADDRESS

George J. Puth 1735 Hayford Ave.

CAUSE OF DEATH is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44139

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

REGISTERED NO. C

CITY OF BALTIMORE: (No. 334 Bismar ST.; 11 WARD)

2-FULL NAME

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 334 Bismar St.; 1 yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE,

WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Woolford
(Address) 334 Bismar St.15- JUN 21 1920 ROBERT E. KRAUTER
Filed 191. Burial Permit Registered

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17 I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on June 19, 1920, and that death occurred, on the date stated above, 20th.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)(Signed) D. H. L. M. D.
(Address) 724 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44140

CERTIFICATE OF DEATH.

180 D44140

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1436 Henry St. ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thomas Clark

(a) RESIDENCE. NO.

1436 Henry

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

35 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

35 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or, WIFE of)

Kate Clark

6 DATE OF BIRTH (month, day, and year)

Dec. 23, 1855

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

64

5

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

B. & O. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

John Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Catherine Connelley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Kate Clark (Wife)
1436 Henry St.

JUN 21 1920

ROBERT B. TRAUTER
Registrar

Burial Permit State

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 17 1920

17

I HEREBY CERTIFY, That I attended deceased from

Feb 1, 1920, to June 17, 1920.

that I last saw him alive on June 17, 1920.

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

At home

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Physical signs

(Signed) S. J. Smith, M. D.

1920 Address 402 W. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cem.

June 21 1920

20 UNDERTAKER

M. J. Flynn

ADDRESS

1422 Light

CAUSE OF DEATH in plain terms, so that it can be understood by laymen. See instructions on back of certificates. TION is very important.

D44141

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

138 D44141

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabelle Virginia Becker(a) RESIDENCE. No. 125 W. Conway ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced
HUSBAND of Kasper Becker
(or) WIFE of6 DATE OF BIRTH (month, day, and year) July 28, 18897 AGE Years 30 Months 11 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.
(State or country)12 MAIDEN NAME OF MOTHER Isabelle Virginia Sheekle13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.
(State or country)

14

Informant Hospital Records
(Address) University Hospital

15

JUN 21 1920
ROBERT F. KRAUTER
Registrar
Burial Permit 0121

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 192017 I HEREBY CERTIFY, That I attended deceased from June 18, 19 20, to June 19, 19 20, that I last saw her alive on June 18, 19 20, and that death occurred, on the date stated above, at 6:15 a.m.

The CAUSE OF DEATH* was as follows:

Ante partum eclampsia(duration) yrs. mos. 2 ds.CONTRIBUTORY Pulmonary Oedema
(Secondary)(duration) yrs. mos. 1 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? Yes Date of June 19, 1920Was there an autopsy? NoWhat test confirmed diagnosis? Clinical Findings(Signed) J. A. Buchness, M. D., 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Western Cemetery June 22 1920

20 UNDERTAKER

Margaret G. Flynn 1450 Righi

CAUSE OF DEATH IN PLAIN ENGLISH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44142

CERTIFICATE OF DEATH.

119 ✓
REGISTERED NO. C

D44142

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *122 S Bethel* ST.; *3* WARD)2-FULL NAME *Elizabeth Camper*(Residence in Baltimore: No. *222 S Bethel* St.; *7* yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)6-DATE OF BIRTH, *June 18, 1869*
(Month) (Day) (Year)7-AGE, *51* yrs. mos. ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *House work*
(b) General nature of industry, business, or establishment in which employed (or employer) *037*9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Alco Smith*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Abeta Pinder*13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Anes Camper*(Address) *222 S Bethel St*15- *JUN 21 1920* *ROBERT B. ELLIOTT*Filed *191* *BATIA* *Patril Clerk*
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 18, 1920*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 8, 1920*, to *June 18, 1920*, that I saw her alive on *June 18, 1920* and that death occurred, on the date stated above, at *m.*

The CAUSE OF DEATH* was as follows:

Cardiac & Respiratory
Paralysis

(Duration) yrs. mos. ds.

CONTRIBUTORY *Acute Bright's Disease*
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Dr. D. Wallerstein* M. D.*June 19, 1920* (Address) *6 S.exter fr*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cambridge* DATE OF BURIAL, *June 29, 1920*20-UNDERTAKER *John W. Henderson* ADDRESS *1302**Monument*

Marie Cook.

Spec. - 6-9-19 - H. P. Co. - 1000 Bks.

D44143

HEALTH DEPARTMENT - CITY OF BALTIMORE

D44143

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cooks Lane ST. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Cook

(a) RESIDENCE. NO. Cooks Lane ST. 28 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, 6 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) md

10 NAME OF FATHER Joseph W. Cook

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) md

12 MAIDEN NAME OF MOTHER Marie Marie Schaff

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) md

14

Informant Joseph W. Cook (Address) Cooks Lane & Edmondson Ave.

15

JUN 21 1920

ROBERT E. LAUTER

Resident

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1920

17

I HEREBY CERTIFY, That I attended deceased from

4:00 pm June 19, 1920 to 11 am June 19, 1920

that I last saw him alive on June 19, 1920

and that death occurred, on the date stated above, at 11 am m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph W. Cook

(Address) Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

June 21, 1920

20 UNDERTAKER

George J. Smith

ADDRESS

1000 W. 1st St.

CAUSE OF DEATH IN PLAIN TERMS, See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D4414T

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mount Hope Rd* ST. *288* WARD)

2-FULL NAME

Harry Wilmering

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

*Baltimore*ST. *not known* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *27* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Sept 25th 1867*

7 AGE

52

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Moulder - 047

(b) General nature of industry, business, or establishment in which employed (or employer)

Iron Work -

(c) Name of employer

*None -*9 BIRTHPLACE (city or town)
(State or country)*Baltimore
Md -*

10 NAME OF FATHER

Frank Wilmering

11 BIRTHPLACE OF FATHER (city or town)

*Hannover
Germany -*

12 MAIDEN NAME OF MOTHER

Anna Tuckan

13 BIRTHPLACE OF MOTHER (city or town)

*Frankfurt
Prussia Germany*

14

Informant
(Address)*Record of Mt Hope Rd
Mt Hope Md -*

15

Filed

JUN 21 1920

ROBERT F. LEATHER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 18th 1920*

17

I HEREBY CERTIFY, That I attended deceased from *June 18th 1920*
that I last saw him alive on *June 18th 1920*
and that death occurred, on the date stated above, at *8:40 P. m.*
The CAUSE OF DEATH* was as follows:*Epilepsy - (Status Epilepticus)**abt* (duration) *17* yrs. *0* mos. *0* ds.CONTRIBUTORY
(Secondary)*Epileptic Mania*(duration) *17* yrs. *0* mos. *0* ds.

18 Where was disease contracted

if not at place of death?

Baltimore Md

Did an operation precede death?

No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Frank Flannery M. D.*June 19, 1920* (Address)*Mt Hope Baltimore Md.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. John's Cemetery**Jun 22 1920*

20 UNDERTAKER

ADDRESS

*W. M. Gaultney**1624 Mt
Regent Ave*

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

D44145

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 60

D44145

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Johns Hopkins Hosp

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

James C. Barley

(n) RESIDENCE. NO.

Fort Lauderdale, Fla.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

2 mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

August 11th 1908

7 AGE

11

Years

Months

10

Days

8

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

child

(b) General nature of industry, business, or establishment in which employed (or employer)

ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Uxion Illinois

10 NAME OF FATHER

James O. Barley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Marion Ind

12 MAIDEN NAME OF MOTHER

Jennie Angelo

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pittsburgh Pa

14

Informant (Address)

Records Johns Hopkins Hosp

15

Filed

JUN 21 1920

ROBERT E. LAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 19 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 19 1920 to June 19 1920

that I last saw him alive on June 19 1920

and that death occurred, on the date stated above, at 6:15 P. m.

The CAUSE OF DEATH* was as follows:

Subcortical abscess of brain (post-operative - following sinus operation January 1920 in Miami Florida) (duration) 6 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Miami, Florida

Did an operation precede death?

Yes Date of Jan - Apr 25

Was there an autopsy?

No May 21

What test confirmed diagnosis?

Operation June 4

(Signed)

Adrian S. Gayton, M. D.

19 (Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Fort Lauderdale Florida

June 21st 1920

20 UNDERTAKER

ADDRESS

George Schilling & Sons

1126 E Monument St

CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D44146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1920 E. Chase

2-FULL NAME

(Residence in Baltimore: No. 1920 E. Chase St.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) Married

6-DATE OF BIRTH,

Aug

26

1860

(Month)

(Day)

(Year)

7-AGE,

59 yrs. 10 mos. 9 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....

Mariner

9-BIRTHPLACE,
(State or Country),

Monie Sm. Co. Md

10-NAME OF
FATHER,

Lem C. White

11-BIRTHPLACE
OF FATHER
(State or Country)

Monie Sm. Co. Md

12-MAIDEN NAME
OF MOTHER

E. White

13-BIRTHPLACE
OF MOTHER
(State or Country),

Monie Sm. Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary M. White

(Address) 1920 E. Chase St.

JUN 21 1920

Filed

BOBBY E. KRAUTER

Bureau of Health

REGISTERED NO. C

ST.: 8 WARD)

(If death occurred in a
hospital or institution,
give its NAME instead
of street and number and
fill out No. 18.)

St.: 20 yrs. mos. ds.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June

(Month)

17, 1917

(Day)

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from
March 1917 to June 17, 1917

that I saw him alive on June 17, 1917

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis Disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Frank J. Ayk

M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS-
FERS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Carmel

20-UNDERTAKER

Geo. W. Pink & Son,

DATE OF BURIAL

JUN 21 1920

ADDRESS

811 N Wolfe

Funeral Directors & Embalmers.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44147

CERTIFICATE OF DEATH.

137✓

D44147

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 N. Robinson ST.;

WARD) 7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Margaret C. Zeman

(a) RESIDENCE. NO.

517 N. Robinson ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofFrank J. Zeman

6 DATE OF BIRTH (month, day, and year)

Nov. 25-1893

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.26625

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Balto Md

10 NAME OF FATHER

Vincent Brush

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Bohemia

12 MAIDEN NAME OF MOTHER

Barbara Klein

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Bohemia

14

Informant

(Address)

Frank J. Zeman
517 N. Robinson St.

15

Filed

JUN 21 1920ROBERT B. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUN 19 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 16, 1920, to June 19, 1920,that I last saw him alive on June 19, 1920,and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Purpural Septicemia(duration) yrs. mos. ds. 7CONTRIBUTORY
(Secondary)Diabetic Endocarditis
(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Wesley J. Ryland, M. D.(Address) 801 N. Greenwood St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer CemJune 20 1920

20 UNDERTAKER

ADDRESS

E. G. Ginn & Son,811 N. Wolfe

Funeral Directors & Embalmers

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

D44148

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Biedler-Sellman Sanatorium 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Claude Melnot Acklen

(a) RESIDENCE. NO.

12 E-Franklin

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

0 yrs. 3 mos. 0 ds.

How long in U. S., if of foreign birth?

63 yrs. 10 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Ella Mason Acklen

6 DATE OF BIRTH (month, day, and year)

July-27-1856

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

63

10

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Cotton Growing

(c) Name of employer

Self

9 BIRTHPLACE (city or town) (State or country)

Nashville Tennessee

10 NAME OF FATHER

Jos. A. S. Acklen

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Huntsville Alabama

12 MAIDEN NAME OF MOTHER

Adalishah Hays

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Nashville Tennessee

14

Informant (Address)

Mr. Jas. W. Lockett - (Bro. in Law) Washington D.C.

15

Filed

JUN 21 1920

ROBERT E. RAUTER Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 19 1920

17

I HEREBY CERTIFY, That I attended deceased from

Dec 1, 1914, to June 18, 1920,

that I last saw him alive on June 18, 1920,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Mitral Insufficiency

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

James C. Clarke, M. D.

(Address)

2419 19 (Address) Latrobe apb.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Nashville-Tennessee

June 20 1920

20 UNDERTAKER

STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44149

D44149

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bay View Hosp.* ST.: *7*)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Wm S. Painter

(a) RESIDENCE. NO.

1037 Mc Donough

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary S. Painter

6 DATE OF BIRTH (month, day, and year)

July 17-1882

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*38**4*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto, Md.

10 NAME OF FATHER

Edward Painter

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto-Md.

12 MAIDEN NAME OF MOTHER

Mary J. Foyman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Mechanic

14

Informant (Address)

Bay View Records

JUN 21 1920

ROBERT B. KRAUTER

Registrar

Baltimore Health Dept.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 20 1920

17

I HEREBY CERTIFY, that I attended deceased from

*June 18, 1920, to June 20, 1920,*that I last saw him alive on *June 19, 1920,*and that death occurred, on the date stated above, at *3:30 a.m.*

The CAUSE OF DEATH* was as follows:

Acute Transverse myelitis(duration) yrs. mos. ds. *28*

CONTRIBUTORY (Secondary)

Terminal Bronchitis(duration) yrs. mos. ds. *2*

18 Where was disease contracted if not at place of death?

*unknown*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Frank T. Barker*, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Health Dept. June 23 1920

20 UNDERTAKER

ADDRESS

Wm. Leake 5026 North Ave

CAUSE OF DEATH IN PARTIALITY OF CERTIFICATE IS VERY IMPORTANT. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44150

CERTIFICATE OF DEATH.

37 D44150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 Ramsey ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Narmi Young

(a) RESIDENCE. NO.

1401 Ramsey ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 31-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt Md

10 NAME OF FATHER

Martin Young

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Fredia Morning

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Martin Young
1401 Ramsey

15

Filed

JUN 21 1920ROBERT E. ELLIOTTRegistrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 20 1920

17

I HEREBY CERTIFY, That I attended deceased from

JUNE 30, 1920, to JUNE 30, 1920that I last saw her alive on JUNE 30, 1920and that death occurred, on the date stated above, at 1030 m.

The CAUSE OF DEATH* was as follows:

Probably and apparently
Septic
(duration) yrs. mos. 29 ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

BirthDid an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) John E. Mose, M. D.(Address) 1520 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn6/21 1920

20 UNDERTAKER

William Cook

ADDRESS

502 E North

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

Dr Mose 1520 Hollins

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Johns Hopkins Hospital* ST.: *16* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Wm. Renshaw*(a) RESIDENCE. NO. *423 N. Washington* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 20 - 1919*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *10*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

C. Child

(b) General nature of industry, business, or establishment in which employed (or employer)

ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Henry Renshaw

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Lillie McKelush

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

J.H.H. Records

15

Filed

*JUN 21 1920**ROBERT E. LAUTER*
Registrar*Barial Permit*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *6-19-1920*

17

I HEREBY CERTIFY, That I attended deceased from

*June 1, 1920, to June 19, 1920,*that I last saw him alive on *June 19, 1920,*and that death occurred, on the date stated above, at *4:20 P.M.*

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia(duration) yrs. mos. ds. *25*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *none*

18 Where was disease contracted if not at place of death?

*Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

X-Ray(Signed) *Harold L. Higgins, M.D.**6/20, 1920 (Address) Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park Cem**June 21 1920*

20 UNDERTAKER

ADDRESS

*J. Herwig & Co**2008 E. E. Ave*

CAUTION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44152

CERTIFICATE OF DEATH.

79
D44152
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3809 E Lombard ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Joh(Residence in Baltimore: No. 3809 E Lombard St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. +4-COLOR OR RACE. W.5-SINGLE, Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH, October 1st, 1855

(Month) (Day) (Year)

7-AGE, 64

yrs. mos. ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
- Housewife
-
- (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City10-NAME OF FATHER, Charles Kieff11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER, Elizabeth Kieff13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Joh(Address) 3809 E Lombard

15-

JUN 21 1920 191... ROBERT S. ELLIOTT
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 19-20, 191...

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1st 1912, to June 19th 1912, that I saw her alive on June 10th 1912 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(Duration) 1 yrs. mos. ds.CONTRIBUTORY (Secondary) none(Signed) Andrew M. M. D.
6/19/12 191... (Address) 291 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn CemDATE OF BURIAL, June 22 192020-UNDERTAKER, J. Herwig & CoADDRESS, 2008 Alcan

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44153

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Josephs Hospital* ST.: *26* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *3928 Fernwood Ave.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1* yrs. *6* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 2 - 1914*7 AGE *5* Years Months *11* Days *18* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md.* (State or country)10 NAME OF FATHER *Joseph J. Fachrkoll.*11 BIRTHPLACE OF FATHER (city or town) *Baltimore Md.* (State or country)12 MAIDEN NAME OF MOTHER *Ida Ermer.*13 BIRTHPLACE OF MOTHER (city or town) *Balto.* (State or country)14 Informant *Joseph J. Fachrkoll.* (Address) *2928 Fernwood Ave.*15 File *JUN 21 1920* ROBERT E. KRAUTER Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 20 1920*17 I HEREBY CERTIFY, That I attended deceased from *June 17, 1920*, to *June 20, 1920*, that I last saw him alive on *June 20, 1920*, and that death occurred, on the date stated above, at *3:25 a.m.*

The CAUSE OF DEATH* was as follows:

Thrombosis of lateral Sinus (mortal origin)(duration) yrs. mos. *10* ds.

CONTRIBUTORY (Secondary)

Myocardial Infarction (duration) yrs. mos. *9* ds.18 Where was disease contracted if not at place of death? *Unknown*Did an operation precede death? *No* Date of *6*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *H. B. McElwain*, M. D., 19 (Address) *St. Josephs Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Oak Lawn Cem.**June 22 1920*

20 UNDERTAKER

ADDRESS

*Lilly and Ziehl**403 S. W. 1st St.*

CAUSE OF DEATH is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44154

CERTIFICATE OF DEATH.

D44154

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 S Easley ST.; 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel H. McCormick(Residence in Baltimore: No. 902 S Easley St.; 1 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

June 7th, 1921
(Month) (Day) (Year)

7-AGE,

13 yrs., 0 mos., 0 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country),

Baltimore City MD

10-NAME OF FATHER,

Carlton H. McCormick

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore City MD

12-MAIDEN NAME OF MOTHER

Anna Heberlein

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore City MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carlton H. McCormick(Address) 902 S Easley St

15-

Filed

JUN 21 1920

ROBERT F. FAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 20th, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 17th 1921, to June 20th 1921,that I saw him alive on June 18th 1921,and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis
(Duration) 4 yrs., 0 mos., 0 ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs., 0 mos., 0 ds.(Signed) J. H. Schwartz M. D.June 21, 1921 (Address) 134 S. E. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Schwartz, Ann.

DATE OF BURIAL

June 22, 1921

20-UNDERTAKER

Lilly and Zeller

ADDRESS

403 S. W. 1st St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44155

CERTIFICATE OF DEATH.

40 D44155

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 8 Green

ST.: 21

WARD)

2-FULL NAME James Benjamin Gross

(a) RESIDENCE: (No. 712 8 Green

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed,
or Divorced (write the word)

Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown 1858

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

62

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Laborer 8440

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Fireman on

(c) Name of employer

Boat

9 BIRTHPLACE (city or town)
(State or country)

Md

10 NAME OF FATHER

Jas Gross

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant
(Address)Mary Deuby 28 Redwood
28 Redwood

15

Filed

JUN 21 1920

ROBERT E. KRAUTER

Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6/19/1920

17

I HEREBY CERTIFY, That I attended, deceased from

June 6th 1920, to June 19th 1920,
that I last saw him alive on June 18th 1920.

and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Robert Co., Ind.

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

6/19/20 19 (Address)

J. H. Toadim 908 58th St

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn

June 21 1920

20 UNDERTAKER

ADDRESS

John H. Toadim 11 Hill St

CAUSE OF DEATH in plain language, see instructions on back of certificates.

D44156

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44156

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.

Hehren Hospital

ST.

14

WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Joseph Liberman

(Residence in Baltimore: No.

241 Laurens Street

St.; yrs.,

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH,

Unknown

1870

7-AGE,

50

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Soda Water
Maker9-BIRTHPLACE,
(State or Country).

Russia

10-NAME OF
FATHER,

Meyer Liberman

11-BIRTHPLACE
OF FATHER
(State or Country).

Russia

12-MAIDEN NAME
OF MOTHER

Rosa

13-BIRTHPLACE
OF MOTHER
(State or Country).

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Leurs

(Address)

1411 E. Balto

15-

ROBERT K. KRAUTER

Filed

JUN 21 1920

Baltimore City Health Department
Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 15, 1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner.)

2-20, 1920 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Hehren Hospital

DATE OF BURIAL,

6/21, 1920

20-UNDERTAKER

Jack Leurs

ADDRESS

1411 E. Balto

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44157

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bay View Hospital* ST.: *7* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *526 N. Becker* ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *34* yrs. *9* mos. *18* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *None*6 DATE OF BIRTH (month, day, and year) *Sept 1 1885*7 AGE Years *35* Months *—* Days *—* If LESS than 1 day, hrs. *—* or min. *—*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md.*10 NAME OF FATHER *Ernest Peters*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Elizabeth Fehle*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Calif.*14 Informant *Ernest Peters* (Address) *3723 Eastern Ave*15 Filed *19* *JUN 21 1920* *ROBERT E. KAUFER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 19th 1920*17 I HEREBY CERTIFY, That I attended deceased from *June 14th*, 19 *20*, to *June 19*, 19 *20*, that I last saw him alive on *June 19th*, 19 *20*, and that death occurred, on the date stated above, at *11 P. M.*

The CAUSE OF DEATH* was as follows:

*Carcinoma of Cervix Uteri*CONTRIBUTORY (Secondary) *Secondary Anemia and Gen. cachexia* (duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *No*(Signed) *Dr. Spalding*, M. D., 19 (Address) *Bay View Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Trinity Cem.**June 22 1920*

20 UNDERTAKER

ADDRESS

*Philip Herwig**2016 Orleans*

CAUSE OF DEATH in plain terms as far as possible. See instructions on back of certificates.

D44158

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44158

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, NO. 2436 Buchanan ST.; 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Rebecca Berryman

(a) RESIDENCE. NO.

2436 Buchanan ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

69

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

JUN 21 1920

ROBERT B. BRADY

Registrar

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 18 1920

I HEREBY CERTIFY, That I attended deceased from June 13, 1920, to June 18, 1920,

that I last saw her alive on June 18, 1920,

and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

CONTRIBUTORY (Secondary) Central Nervous System (duration) yrs. 6 mos. ds.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) Dr. H. H. H. M. D.

, 19 (Address) 1118 Drexel Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Catholic Cemetery

June 22nd 1920

20 UNDERTAKER

ADDRESS

Chas. & B. B. B.

1411

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44159

CERTIFICATE OF DEATH.

D44159

PLACE OF DEATH

CITY OF BALTIMORE (No. 1)

2-FULL NAME

(Residence in Baltimore: No. 425)

Bantaum

WARD) 5

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: (yrs., 2) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed JUN 21 1920

ROBERT A. BAUTER

Bureau of Health

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner.)

M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

D44160

CERTIFICATE OF DEATH

30 D44160
REGISTERED NO. C

PLACE OF DEATH
CITY OF BALTIMORE (No. Sydenham Hospital ST. WARD)
2-FULL NAME Mildred Jones
(Residence in Baltimore: No. 249 W. Hoffman St. 3 yrs. 3 mos. 3 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX female 4-COLOR OR RACE Col. 5-SINGLE, MARRIED, WIDOWED OR DIVORCED single.
6-DATE OF BIRTH March 16, 1917
7-AGE 3 yrs. 3 mos. 3 ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION (a) Trade, profession, or particular kind of work house. (b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE (State or country) Wld.
10-NAME OF FATHER Joseph Jones (dead)
11-BIRTHPLACE OF FATHER (State or country) Wld.
12-MAIDEN NAME OF MOTHER Ethel Ball.
13-BIRTHPLACE OF MOTHER (State or country) Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Ethel Jones
(Address) 249 W. Hoffman

15- JUN 21 1920 ROBERT B. LEAUTEY
Filed 191 Serial 1001 REGISTAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 16, 1920, to June 19, 1920, that I saw her alive on June 19, 1920, and that death occurred, on the date stated above, at 4:10 P. m.
The CAUSE OF DEATH* was as follows:

Tuberculous meningitis
(autopsy)
(Duration) yrs. mos. 17 ds.

Contributory (SECONDARY) none
(Duration) yrs. mos. ds.

(Signed) B. Macfarlan M. D.
June 20, 1920 (Address) Sydenham Hospital

*State the DISEASE CAUSING DEATH, or, deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. 4 ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death? at home.
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

St. Auburn
20-UNDERTAKER Edu. W. Pye

DATE OF BURIAL June 21, 1920
ADDRESS 903
Edmondson

D44161

HEALTH DEPARTMENT—CITY OF BALTIMORE

Masterman
CERTIFICATE OF DEATH.

43 D44161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St.; 19 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No.

St.; 10 yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUN 21 1920

191

ROBERT B. KRAUTER
Social Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

6 19 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 2nd 1919 to June 19th 1920,

that I saw him alive on June 19 1920,

and that death occurred, on the date stated above, at 4⁰⁰ p. m.

The CAUSE OF DEATH*, was as follows:

Meningitis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) M. D.

June 21, 1920 (Address) 2432 4th Ave. S.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Cathedral Cemetery June 21 1920

20-UNDERTAKER

ADDRESS 2236 W.

H. J. Hartwell Baltimore St.

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44162

CERTIFICATE OF DEATH.

28

D44162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Bay view Hospital

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lena Barlow

(a) RESIDENCE. NO.

1718 Aliceanna

ST. Str.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Don't know

ds.

How long in U. S., if of foreign birth?

Don't know

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Don't know

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

57.

✓

✓

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Born in Germany

10 NAME OF FATHER

George Balk

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Hospital Records
Bayview Hospital

15

JUN 21 1920

ROBERT A. ELLIOTT

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 19 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 20, 1920, to June 19, 1920,

that I last saw her alive on June 19, 1920,

and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

Tubercular Sarcoidosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Don't know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Tubercle Bacillus in sputum

(Signed) George R. Wilkinson, M. D.

, 19 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Carmel

June 21 1920

20 UNDERTAKER

ADDRESS

Robert J. Turner

1442
St. Mary

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44163

D44163

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital*)ST.: *H 12* W *1* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Edwin Biddle(Residence in Baltimore: No. *3209 N. Charles St*)St.: *40* yrs. *4* mos. *7* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH,

Feb. 12, *1858*
(Month) (Day) (Year)

7-AGE,

62 yrs. *4* mos. *7* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Broker

9-BIRTHPLACE, (State or Country),

Philadelphia Pa

10-NAME OF FATHER,

Jonathan S Biddle

11-BIRTHPLACE OF FATHER (State or Country),

Pa

12-MAIDEN NAME OF MOTHER

Rusan Erdman

13-BIRTHPLACE OF MOTHER (State or Country),

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Records of Johns Hopkins Hospital*

(Address)

15-

JUN 21 1920

Filed

191

ROBERT S. LEAVITT

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 19, *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 25 *1920*, to *June 19* *1920*,that I saw him alive on *June 19* *1920*,and that death occurred, on the date stated above, at *3:50 P* m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(Duration) *0* yrs. *0* mos. *3* ds.

CONTRIBUTORY (Secondary)

Pulmonary edema(Duration) *0* yrs. *0* mos. *1* ds.(Signed) *Geo. L. Stevenson* M. D.*June 19*, *1920* (Address) *J. H. H. Balt. Md*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *1* mos. *26* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cemetery

DATE OF BURIAL,

June 21, *1920*

20-UNDERTAKER

H. E. Hughes 175 Broadway

ADDRESS

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44164

CERTIFICATE OF DEATH.

D44164

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1421 S. Cary St. 21

ST.: 21 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Adolph E. Backhaus

(a) RESIDENCE. No. 1421 S. Cary St.

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Lifetime

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 31 - 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

0

5

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None - 100

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

10 NAME OF FATHER

Albert Backhaus

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

Herta Kiepsch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

Albert Backhaus

(Address)

1421 S. Cary St.

15

JUN 21 1920

ROBERT E. BAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 20 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 10, 1920, to June 20, 1920,

that I last saw him alive on June 20, 1920,

and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

Acute Catarrh of Rectum 3 days

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. C. Freisinger M. D.

682 Columbia Ave -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

DATE OF BURIAL

June 22 1920

20 UNDERTAKER

Mr. Mrs. John W. Tenfel

ADDRESS

801 N. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44165

D44165

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 10 WARD)

2-FULL NAME

William F. Coffey

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 1208 N. Central Ave ST. 10 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Apr 18 1867

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

532

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

American Express Co

(c) Name of employer

Obv

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Wm. Coffey

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Haugherty

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant
(Address)Miss Coffey
1208 Central Ave

15

Filed

JUN 21 1920ROBERT F. KAUFMAN
Registrar

Baltimore Health Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 19 20

17

I HEREBY CERTIFY, That I attended deceased from April 4 19 20 to June 19 19 20that I last saw him alive on June 19 19 20and that death occurred, on the date stated above, at 12:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 5 Metastatic Adeno-Sarcoma

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date ofWas there an autopsy? NOWhat test confirmed diagnosis? Physical Signs(Signed) J. B. Bronushas, M. D.(Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

CathedralJune 22 1920

20 UNDERTAKER

H. C. Wiedefeld

ADDRESS

914 Greenmount AveCAUSE OF DEATH
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D44166

D44166

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 N. BondST.: 22

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernice S. Baker(a) RESIDENCE. NO. 500 N. Bond

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE col

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1918

7 AGE

Years 2Months 0Days 0

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 100

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md10 NAME OF FATHER Ervin Baker

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Syracuse N.Y.12 MAIDEN NAME OF MOTHER Amelia May Murray

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Orangeburg S.C.

14

Informant Ervin Baker(Address) 1000 Mt Vernon St

15

Filed

19

ROBERT E. FRANKLIN

Registrar

JUN 21 1920

Burial Permit Class

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1920

17

HEREBY CERTIFY, That I attended deceased from

June 13, 1920, to June 20, 1920,that I last saw him alive on June 20, 1920,and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute Capillary Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd M. D.(Address) 602 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Int. Lutheran Cemetery6/22/20

20 UNDERTAKER

ADDRESS

Mrs. Geo. H. Hooper6/22/20

CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44167

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2371 W. North Ave. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Carrie Duce

(a) RESIDENCE. No.

2371 W. North Ave

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced (write the word) Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of Feb. 6 - 1843 -

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
75 4 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Charles Duce

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Annie Duce 2371 W. North Ave.

JUN 21 1920

ROBERT K. KAUTER

Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1920

17

I HEREBY CERTIFY, That I attended deceased from May - 1919, to June 20, 1920, that I last saw her alive on June 19, 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Stenosis & Mitral Regurgitation

CONTRIBUTORS (Secondary)

(duration) 2 yrs. mos. ds.

(duration) - yrs. - mos. 3 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Thomas J. Talbot, M.D.

19 (Address)

Marlborough Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Silver Run Carroll Co Md

June 22 1920

20 UNDERTAKER

Josiah Syfer

ADDRESS

1601 W. North Ave

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44168

D44168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *2106 Clendenale Rd.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2 yrs* mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Child*

6 DATE OF BIRTH (month, day, and year)

March 17-1920

7 AGE

Years

3

Months

4

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore, Md.*

10 NAME OF FATHER

James Har

11 BIRTHPLACE OF FATHER (city or town)

Pa.

(State or country)

12 MAIDEN NAME OF MOTHER

Elizabeth Kelly

13 BIRTHPLACE OF MOTHER (city or town)

Pa.

(State or country)

14

Informant
(Address)*Hospital Record
1111*

15

Filed *1920* Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 21 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*June 16, 1920, to June 21, 1920*that I last saw him alive on *June 21, 1920,*and that death occurred, on the date stated above, at *4:20 a.m.*

The CAUSE OF DEATH* was as follows:

*Acute gastro-intestinal
indigestion*(duration) yrs. mos. *9* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

*Home*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Harold L. Higgins*, M. D.*6/21, 1920* Address *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Philadelphia Pa.**June 21 1920*

20 UNDERTAKER

ADDRESS

Chas. F. Evans & Son 118 West Royal Ave

D44169

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 Jefferson ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Horsey(a) RESIDENCE. No. 1612 Jefferson ST.: 7 WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col. 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Horsey6 DATE OF BIRTH (month, day, and year) Unknown / 8657 AGE Years 65 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labourer 240(b) General nature of industry, business, or establishment in which employed (or employer) Labour(c) Name of employer —9 BIRTHPLACE (city or town) Unknown (State or country) md10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown14 Informant Elizabeth Haskins (Address) 1612 Jefferson15 Filed Robert P. Harrison, RegistrarBurial Parish Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 192017 I HEREBY CERTIFY, That I attended deceased from June 13, 1920, to June 18, 1920, that I last saw him alive on June 18, 1920, and that death occurred, on the date stated above, at 12340 p m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitationCONTRIBUTORY (Secondary) Acute nephritis (duration) 1 yrs. mos. ds.18 Where was disease contracted if not at place of death? At homeDid an operation precede death? no Date of —Was there an autopsy? yesWhat test confirmed diagnosis? Clinical(Signed) M. D. Robin M. D.(Address) 1830 Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Drake Island Md DATE OF BURIAL June 20 192020 UNDERTAKER Mrs Root a reliefADDRESS 735

CAUSE OF DEATH IN plain terms, so that laymen can understand. See instructions on back of certificates.

JUN 21 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44170

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Vincent Ins. Asylum* ST. *14* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *1401 Division St.* ST. *14* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. ds. How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female**White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

76 years

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sister of Charity

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Boston Mass

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

*Sister Sara**St. Vincent Asylum*

15

19

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 21 1920

17

I HEREBY CERTIFY, That I attended deceased from *April 12 1920* to *June 21 1920*that I last saw her alive on *June 21 1920*and that death occurred, on the date stated above, at *8 A.* m.

The CAUSE OF DEATH* was as follows:

Ch. Myocarditis(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis(duration) *5* yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

yes

Did an operation precede death?

Date of

Was there an autopsy?

yes

What test confirmed diagnosis?

Chronic

(Signed)

Chas. Helander M. D.

Date, 1920 (Address)

1504 McCallloch St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cathedral**June 23 1920*

20 UNDERTAKER

ADDRESS

Martin Fabry *Adm 27 W. 1st St.*

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificate.

JUN 21 1920

D44171

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44171

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 W. Mulberry ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Valentine

(a) RESIDENCE. NO. 13 W. Mulberry

(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 1 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Loftus

6 DATE OF BIRTH (month, day, and year) April 27, 1854

7 AGE 66 Years 1 Months 23 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retail Fruit 045

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

10 NAME OF FATHER Francis J. Valentine

11 BIRTHPLACE OF FATHER (city or town) Austria (State or country) Hungary

12 MAIDEN NAME OF MOTHER Mary R. Podesta

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant Francis J. Valentine (Address) 13 W. Mulberry Street

15 Filed JUN 21 1920 P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1920

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1920, to June 19, 1920, that I last saw him alive on June 18, 1920,

and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY Cerebral Arterio Sclerosis (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Carroll Lockard, M. D.

June 21 1920 Address 4 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Cemetery 6/22 1920

20 UNDERTAKER ADDRESS

Henry W. Mears & Son 805 N. Calvert St.

Burial Permit Clerk.

CAUSE OF DEATH IN FULL. See instructions on back of certificates. TION is very important.

N. B.-Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D44172

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1117 Montipeliar Avenue

ST. 9 WARD)

2-FULL NAME Catherine Holt

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1117 Montipeliar Avenue

St. 45 yrs. -- mos. -- ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female
4-COLOR OR RACE White
5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widow
6-DATE OF BIRTH April 29, 1830
(Month) (Day) (Year)
7-AGE 90 1 21
yrs. mos. ds. If LESS than 1 day, hrs. or mts.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

Pennsylvania

PARENTS

10-NAME OF FATHER

Do not know

11-BIRTHPLACE OF FATHER
(State or country)

Do not know

12-MAIDEN NAME OF MOTHER

Do not know

13-BIRTHPLACE OF MOTHER
(State or country)

Do not know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. Frank Eline

(Address) 225 E. Lafayette Avenue

15.

JUN 21 1920 Robert P. Harrison,

Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 20, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5, 1920, to June 18, 1920, that I saw him alive on June 18, 1920, and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows:

Mitral Disease of heart.

(Duration) 3 yrs. mos. ds.

Contributory Arteriosclerosis & Anemia (SECONDARY)

(Duration) 10 yrs. mos. ds.

(Signed) H. J. Stickler M. D.
June 20, 1920 (Address) 632 Gorman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL
Cathedral Cemetery

DATE OF BURIAL
6/23, 1920

20-UNDERTAKER

Henry W. Mears & Son 805 N. Calvert St.

ADDRESS

D44173

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓ D44173
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital* St. *1* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mr. Vincent Nasha*(Residence in Baltimore: No. *282 S. Robinson* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *male*4-COLOR OR RACE *white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,, 1

(Month)

(Day)

(Year)

7-AGE, *27* yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Italy*10-NAME OF FATHER, *Stalipa*

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

*Robert P. Harrison, Johns**Burial Permit Clerk*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 18, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 7, 1920*, to *June 18, 1920*, that I saw him alive on *June 18, 1920*, and that death occurred, on the date stated above, at *6 A. m.*

The CAUSE OF DEATH* was as follows:

Tuberculosis? Lungs, Intestines & Peritonitis

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Meningitis*

..... (Duration) yrs. mos. ds.

(Signed) *Black*

M. D.

June 18, 1920 (Address) *Hebrew Hosp. 28*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *JOHNS HOPKINS HOSPITAL*DATE OF BURIAL, *JUN. 2, 1920*20-UNDERTAKER *Commissioner Health*

ADDRESS

Per. Wm. E. WOODALL

important. See instructions on back of certificate.

JUN 21 1920

17305

D44173

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44173

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *17* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Robert. Wick.

(a) RESIDENCE. NO.

Detroit Michigan 70. Dr. H. T. Groose Pt.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 5 - 1919

7 AGE

Years

Months

Days

If LESS than 1 day, ... hrs. or ... min.

9

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

New York

10 NAME OF FATHER

J. Fiske. Wick.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

New York

12 MAIDEN NAME OF MOTHER

Anna Wagner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ohio

14

Informant

J. H. H. Records

(Address)

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 19 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 17, 1920, to June 19, 1920,

that I last saw him alive on *June 19, 1920,*

and that death occurred, on the date stated above, at *5:15 P. M.*

The CAUSE OF DEATH* was as follows:

Congenital cystic kidney

(duration) yrs. *9* mos. ds.

CONTRIBUTORY (Secondary)

none

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Autopsy*

(Signed) *Harold L. Higgins M. D.*

6/21/1920 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Bay Shore Long Island

June 22 1920

20 UNDERTAKER

ADDRESS

Wm. C. Black 927 N. Broadway

CAUSE OF DEATH is very important. See instructions on back of certificates.

JUN 21 1920

D44175

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

61-001/D44175
REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 5

WARD)

2-FULL NAME

Sydenham Hospital
Harry Miller

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 527 Asquith St.

St.; yrs. 7 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

white

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

single

6-DATE OF BIRTH

Nov.

17, 1919

(Month)

(Day)

(Year)

7-AGE

7 4

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

unemployed

9-BIRTHPLACE
(State or country)

Md.

10-NAME OF
FATHER

Hyman Miller

PARENTS

11-BIRTHPLACE
OF FATHER
(State or country)

Russia

12-MAIDEN NAME
OF MOTHER

Bessie Seltzman

13-BIRTHPLACE
OF MOTHER
(State or country)

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Hyman Miller

(Address)

527 Asquith St.

15

Robert P. Harrison,

REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June

20, 1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from

June 14, 1920, to June 20, 1920

that I saw him alive on June 20, 1920

and that death occurred, on the date stated above, at 11:45 P.m.

The CAUSE OF DEATH* was as follows:

Epidemic meningitis.

(Duration) yrs. mos. 21 ds.

Contributory
(SECONDARY)

none

(Duration) yrs. mos. ds.

(Signed),

Blacksburg M. D.

June 21, 1920

(Address) Sydenham Hospital.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. 7 ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death? at home.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hebrew Mt. Carmel

June 21, 1920

20-UNDERTAKER

ADDRESS 7627 E

Max Lurson

Baltimore

JUN 21 1920

N. B.-Every item of information should be carefully supplied. Do not state statement of occupation in plain terms, so that it may be properly classified. is very important. See instructions on back of certificate.

D44176

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44176

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

539 W Lee

ST.: 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles C. Seymour

(a) RESIDENCE. NO.

539 W Lee

ST.: 22 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Annie C. Seymour

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

75

8

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Glass Blower

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

None

9 BIRTHPLACE (city or town)
(State or country)

New York

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

New York

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

New York

14

Informant
(Address)Mrs Ella Seymour
539 W Lee

15

filed

19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 20 1920

17

HEREBY CERTIFY, That I attended deceased from

Jan. 1920, to June 20, 1920,

that I last saw him alive on Jan. 18, 1920.

and that death occurred, on the date stated above, at 2:15 a.m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) 4 yrs. 4 mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. G. Smith, M. D.

1920 (Address)

517 Locust St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Olivet Cemetery

June 22 1920

20 UNDERTAKER

ADDRESS 1539

Schloman & Son

Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

D44177

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D44177

1-PLACE OF DEATH

CITY OF BALTIMORE: (Municipal Tuberculosis Hospital 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Hawkins

(a) RESIDENCE. NO. 1418 Kutter St.

ST. WARD.

(Usual place of abode)

30 years

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown

mos.

ds. How long in U. S., if of foreign birth?

30 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

Female Colored

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Widow John Hawkins

6 DATE OF BIRTH (month, day, and year)

1874

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

46

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Domestic

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Unknown

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town)
(State or country)

Virginia

10 NAME OF FATHER

Tom Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Susan Banks

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant
(Address)

Hospital Records

H.T.H.

15

File

Robert P. Harrison,

Burial Permit Clerk,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1920

17

I HEREBY CERTIFY, That I attended deceased from
March 17, 1920, to June 21, 1920.

that I last saw her alive on June 20, 1920.

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY Pleural effusion
(Secondary)

(duration) yrs. 5 mos. ds.

18 Where was disease contracted

if not at place of death? unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed)

George R. Wilkinson, M. D.

6-21-20

19

(Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Lamuel Perry June 23, 1920
11th Rock 5026 North Ave

D44178

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44178

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1048 N. Durham ST. 7 WARD)2-FULL NAME Henrietta Foreman

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 1048 N. Wolfe St ST. 7 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. and over ds. How long in U. S., if of foreign birth? 20 yrs. 6 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Widow of John Foreman</u>
------------------------	---------------------------------	--

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of widow of John Foreman6 DATE OF BIRTH (month, day, and year) May 4-1848

7 AGE <u>72</u>	Years	Months <u>1</u>	Days <u>16</u>	If LESS than 1 day, hrs. or min.
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8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Balt Md

10 NAME OF FATHER

Joshua Bunch11 BIRTHPLACE OF FATHER (city or town)
(State or country)Don't Know

12 MAIDEN NAME OF MOTHER

Henrietta Babery13 BIRTHPLACE OF MOTHER (city or town)
(State or country)France

14

Informant
(Address)Elizabeth W. McDaniel
1048 N. Durham Street
Robert P. Harrison,

UN 21-1920

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6, 20 20 1920

17 I HEREBY CERTIFY, That I attended deceased from January 20, 1920, to June 20, 1920, that I last saw her alive on one June 20, 1920, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Intermittent Phnefritis and
Gastritis (and Complications)

(duration) yrs. mos.

CONTRIBUTORY
(Secondary)(duration) over yrs. 3 mos. 4 ds.18 Where was disease contracted
if not at place of death?at Her Home
1048 N. DurhamDid an operation precede death? No Date of.Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas J. Simms M. D.19 (Address) 1048 N. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London ParkJune 22-1920

20 UNDERTAKER

William Cook

ADDRESS

502 E. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44179

D44179

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2409 Fleet

ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Roszko

(Residence in Baltimore: No. 2409 Fleet

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, June 20, 1920

(Month)

(Day)

(Year)

7-AGE, 18

LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, W. Center Roszko

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Wladyslawa

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert R. Krauter

(Address) 2409 Fleet

15- JUN 22 1920 ROBERT R. KRAUTER

Filed..... 1918-21-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098-1099-1100-1101-1102-1103-1104-1105-1106-1107-1108-1109-1110-1111-1112-1113-1114-1115-1116-1117-1118-1119-1120-1121-1122-1123-1124-1125-1126-1127-1128-1129-1130-1131-1132-1133-1134-1135-1136-1137-1138-1139-1140-1141-1142-1143-1144-1145-1146-1147-1148-1149-1150-1151-1152-1153-1154-1155-1156-1157-1158-1159-1160-1161-1162-1163-1164-1165-1166-1167-1168-1169-1170-1171-1172-1173-1174-1175-1176-1177-1178-1179-1180-1181-1182-1183-1184-1185-1186-1187-1188-1189-1190-1191-1192-1193-1194-1195-1196-1197-1198-1199-1200-1201-1202-1203-1204-1205-1206-1207-1208-1209-1210-1211-1212-1213-1214-1215-1216-1217-1218-1219-1220-1221-1222-1223-1224-1225-1226-1227-1228-1229-1230-1231-1232-1233-1234-1235-1236-1237-1238-1239-1240-1241-1242-1243-1244-1245-1246-1247-1248-1249-1250-1251-1252-1253-1254-1255-1256-1257-1258-1259-1260-1261-1262-1263-1264-1265-1266-1267-1268-1269-1270-1271-1272-1273-1274-1275-1276-1277-1278-1279-1280-1281-1282-1283-1284-1285-1286-1287-1288-1289-1290-1291-1292-1293-1294-1295-1296-1297-1298-1299-1300-1301-1302-1303-1304-1305-1306-1307-1308-1309-1310-1311-1312-1313-1314-1315-1316-1317-1318-1319-1320-1321-1322-1323-1324-1325-1326-1327-1328-1329-1330-1331-1332-1333-1334-1335-1336-1337-1338-1339-1340-1341-1342-1343-1344-1345-1346-1347-1348-1349-1350-1351-1352-1353-1354-1355-1356-1357-1358-1359-1360-1361-1362-1363-1364-1365-1366-1367-1368-1369-1370-1371-1372-1373-1374-1375-1376-1377-1378-1379-1380-1381-1382-1383-1384-1385-1386-1387-1388-1389-1390-1391-1392-1393-1394-1395-1396-1397-1398-1399-1400-1401-1402-1403-1404-1405-1406-1407-1408-1409-1410-1411-1412-1413-1414-1415-1416-1417-1418-1419-1420-1421-1422-1423-1424-1425-1426-1427-1428-1429-1430-1431-1432-1433-1434-1435-1436-1437-1438-1439-1440-1441-1442-1443-1444-1445-1446-1447-1448-1449-1450-1451-1452-1453-1454-1455-1456-1457-1458-1459-1460-1461-1462-1463-1464-1465-1466-1467-1468-1469-1470-1471-1472-1473-1474-1475-1476-1477-1478-1479-1480-1481-1482-1483-1484-1485-1486-1487-1488-1489-1490-1491-1492-1493-1494-1495-1496-1497-1498-1499-1500-1501-1502-1503-1504-1505-1506-1507-1508-1509-1510-1511-1512-1513-1514-1515-1516-1517-1518-1519-1520-1521-1522-1523-1524-1525-1526-1527-1528-1529-1530-1531-1532-1533-1534-1535-1536-1537-1538-1539-1540-1541-1542-1543-1544-1545-1546-1547-1548-1549-1550-1551-1552-1553-1554-1555-1556-1557-1558-1559-1560-1561-1562-1563-1564-1565-1566-1567-1568-1569-1570-1571-1572-1573-1574-1575-1576-1577-1578-1579-1580-1581-1582-1583-1584-1585-1586-1587-1588-1589-1590-1591-1592-1593-1594-1595-1596-1597-1598-1599-1600-1601-1602-1603-1604-1605-1606-1607-1608-1609-1610-1611-1612-1613-1614-1615-1616-1617-1618-1619-1620-1621-1622-1623-1624-1625-1626-1627-1628-1629-1630-1631-1632-1633-1634-1635-1636-1637-1638-1639-1640-1641-1642-1643-1644-1645-1646-1647-1648-1649-1650-1651-1652-1653-1654-1655-1656-1657-1658-1659-1660-1661-1662-1663-1664-1665-1666-1667-1668-1669-1670-1671-1672-1673-1674-1675-1676-1677-1678-1679-1680-1681-1682-1683-1684-1685-1686-1687-1688-1689-1690-1691-1692-1693-1694-1695-1696-1697-1698-1699-1700-1701-1702-1703-1704-1705-1706-1707-1708-1709-1710-1711-1712-1713-1714-1715-1716-1717-1718-1719-1720-1721-1722-1723-1724-1725-1726-1727-1728-1729-1730-1731-1732-1733-1734-1735-1736-1737-1738-1739-1740-1741-1742-1743-1744-1745-1746-1747-1748-1749-1750-1751-1752-1753-1754-1755-1756-1757-1758-1759-1760-1761-1762-1763-1764-1765-1766-1767-1768-1769-1770-1771-1772-1773-1774-1775-1776-1777-1778-1779-1780-1781-1782-1783-1784-1785-1786-1787-1788-1789-1790-1791-1792-1793-1794-1795-1796-1797-1798-1799-1800-1801-1802-1803-1804-1805-1806-1807-1808-1809-1810-1811-1812-1813-1814-1815-1816-1817-1818-1819-1820-1821-1822-1823-1824-1825-1826-1827-1828-1829-1830-1831-1832-1833-1834-1835-1836-1837-1838-1839-1840-1841-1842-1843-1844-1845-1846-1847-1848-1849-1850-1851-1852-1853-1854-1855-1856-1857-1858-1859-1860-1861-1862-1863-1864-1865-1866-1867-1868-1869-1870-1871-1872-1873-1874-1875-1876-1877-1878-1879-1880-1881-1882-1883-1884-1885-1886-1887-1888-1889-1890-1891-1892-1893-1894-1895-1896-1897-1898-1899-1900-1901-1902-1903-1904-1905-1906-1907-1908-1909-1910-1911-1912-1913-1914-1915-1916-1917-1918-1919-1920-1921-1922-1923-1924-1925-1926-1927-1928-1929-1930-1931-1932-1933-1934-1935-1936-1937-1938-1939-1940-1941-1942-1943-1944-1945-1946-1947-1948-1949-1950-1951-1952-1953-1954-1955-1956-1957-1958-1959-1960-1961-1962-1963-1964-1965-1966-1967-1968-1969-1970-1971-1972-1973-1974-1975-1976-1977-1978-1979-1980-1981-1982-1983-1984-1985-1986-1987-1988-1989-1990-1991-1992-1993-1994-1995-1996-1997-1998-1999-2000-2001-2002-2003-2004-2005-2006-2007-2008-2009-2010-2011-2012-2013-2014-2015-2016-2017-2018-2019-2020-2021-2022-2023-2024-2025-2026-2027-2028-2029-2030-2031-2032-2033-2034-2035-2036-2037-2038-2039-2040-2041-2042-2043-2044-2045-2046-2047-2048-2049-2050-2051-2052-2053-2054-2055-2056-2057-2058-2059-2060-2061-2062-2063-2064-2065-2066-2067-2068-2069-2070-2071-2072-2073-2074-2075-2076-2077-2078-2079-2080-2081-2082-2083-2084-2085-2086-2087-2088-2089-2090-2091-2092-2093-2094-2095-2096-2097-2098-2099-2100-2101-2102-2103-2104-2105-2106-2107-2108-2109-2110-2111-2112-2113-2114-2115-2116-2117-2118-2119-2120-2121-2122-2123-2124-2125-2126-2127-2128-2129-2130-2131-2132-2133-2134-2135-2136-2137-2138-2139-2140-2141-2142-2143-2144-2145-2146-2147-2148-2149-2150-2151-2152-2153-2154-2155-2156-2157-2158-2159-2160-2161-2162-2163-2164-2165-2166-2167-2168-2169-2170-2171-2172-2173-2174-2175-2176-2177-2178-2179-2180-2181-2182-2183-2184-2185-2186-2187-2188-2189-2190-2191-2192-2193-2194-2195-2196-2197-2198-2199-2200-2201-2202-2203-2204-2205-2206-2207-2208-2209-2210-2211-2212-2213-2214-2215-2216-2217-2218-2219-2220-2221-2222-2223-2224-2225-2226-2227-2228-2229-2230-2231-2232-2233-2234-2235-2236-2237-2238-2239-2240-2241-2242-2243-2244-2245-2246-2247-2248-2249-2250-2251-2252-2253-2254-2255-2256-2257-2258-2259-2260-2261-2262-2263-2264-2265-2266-2267-2268-2269-2270-2271-2272-2273-2274-2275-2276-2277-2278-2279-2280-2281-2282-2283-2284-2285-2286-2287-2288-2289-2290-2291-2292-2293-2294-2295-2296-2297-2298-2299-2300-2301-2302-2303-2304-2305-2306-2307-2308-2309-2310-2311-2312-2313-2314-2315-2316-2317-2318-2319-2320-2321-2322-2323-2324-2325-2326-2327-2328-2329-2330-2331-2332-2333-2334-2335-2336-2337-2338-2339-2340-2341-2342-2343-2344-2345-2346-2347-2348-2349-2350-2351-2352-2353-2354-2355-2356-2357-2358-2359-2360-2361-2362-2363-2364-2365-2366-2367-2368-2369-2370-2371-2372-2373-2374-2375-2376-2377-2378-2379-2380-2381-2382-2383-2384-2385-2386-2387-2388-2389-2390-2391-2392-2393-2394-2395-2396-2397-2398-2399-2400-2401-2402-2403-2404-2405-2406-2407-2408-2409-2410-2411-2412

D44180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44180

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1337 N. Mount St. 15 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 1337 N. Mount St. WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Col* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *John Clutterback*6 DATE OF BIRTH (month, day, and year) *1854*7 AGE *66* Years Months Days If LESS than 1 day, *hrs.* or *min.*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Domestic -*(b) General nature of industry, business, or establishment in which employed (or employer) *General house work*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Frederick, Md.*10 NAME OF FATHER *Robert Jackson*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Frederick, Md.*12 MAIDEN NAME OF MOTHER *Matilda Hutchinson*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Virginia*14 Informant (Address) *Matilda Maynard 1337 N. Mount St.*15 Filed *JUN 22 1920* ROBERT B. FRANTZ Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 20 1920*17 I HEREBY CERTIFY, That I attended deceased from *May 29 1920* to *June 18 1920*that I last saw him alive on *June 18 1920*and that death occurred, on the date stated above, at *1:30 p.m.*

The CAUSE OF DEATH* was as follows:

Paralysis (Apoplexy)(duration) yrs. mos. *20* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *J. E. ...* M. D.(Address) *1524 ...*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*mt Zion**June 22 1920*

20 UNDERTAKER

ADDRESS

Edward Ringgold 1463 ...

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44181

CERTIFICATE OF DEATH.

47 D44181

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1915 N. Collington St. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Artella R. Justice

(a) RESIDENCE

No. 1915 N. Collington

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1 1/2* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

January 26th 1910

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

10

4

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt.

10 NAME OF FATHER

William E. Justice

11 BIRTHPLACE OF FATHER (city or town) (State or country)

W. Carolina

12 MAIDEN NAME OF MOTHER

Lannie E. Brashear

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt.

14

Informant (Address)

Mr. William E. Justice 1915 N. Collington

15

Filed

JUN 22 1920

ROBERT A. LEATHER

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-20 1920

17

I HEREBY CERTIFY, That I attended deceased from

6-11-20, 1920, to 6-20, 1920

that I last saw her alive on 6-20-1920

and that death occurred, on the date stated above, at 7:15 A. M.

The CAUSE OF DEATH* was as follows:

Acute Pleurisy

(duration) yrs. mos. ds. 14

CONTRIBUTORY (Secondary)

Acute Carditis

(duration) yrs. mos. ds. 7

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

77rd Ruzicka M. D. 100 N. Pittman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Olivet Cemetery

June 23 1920

20 UNDERTAKER

ADDRESS

Henry Hoeck Law

1301 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44182

D44182

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

824 North Mount

ST.:

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Rose Nowitz

(Residence in Baltimore: No.

824 N. Mount

St.; yrs. mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6-DATE OF BIRTH.

June 7

1920

7-AGE,

yrs. mos. 14 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Child

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Daniel Nowitz

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Bessie Leslie

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

D. Nowitz

(Address)

824 N. Mount

15-

JUN 22 1920

ROBERT A. KRAUTER

BALTIMORE CITY REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 21, 1920

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 20th 1920 to June 21st 1920,that I saw him alive on June 21st 1920,

and that death occurred, on the date stated above, at 5.45 P. M.

The CAUSE OF DEATH* was as follows:

Bronchitis Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 1 ds.

(Signed) Leonard M. C. Parker M. D.

June 22, 1920 (Address) 1144 Harford Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Wesley Roseedale

June 22, 1920

20-UNDERTAKER

ADDRESS

Jack Lewis, 1411 E. Baltimore

CAUSE OF DEATH IN plain terms, as far as possible, on back of certificate. important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44183

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3304 Schuck

ST.: 76 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 3304 Schuck

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Lena Wright

6 DATE OF BIRTH (month, day, and year) Sept 15, 1847

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

72 9 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Stevadore

Retired 15 years

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Not Known

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not Known

14

Informant (Address)

Lena Wright 3304 Schuck St.

15

JUN 22 1920

ROBERT A. KAUTEE

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to June 21, 1920,

that I last saw him alive on June 19, 1920, and that death occurred, on the date stated above, at 8:20 A. M.

The CAUSE OF DEATH* was as follows:

Mitral & Aortic Insufficiency

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

(duration) 1 yrs. mos. 21 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. Fitch, M. D.

6/22 1920 (Address) 2504 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL

DATE OF BURIAL

Oak Lawn Cem. June 23 1920

20 UNDERTAKER

ADDRESS

H. Sander Son 1710 Park St.

CAUSE OF DEATH in plain terms, so that it may be put on back of certificates. See instructions on back of certificates.

Dr. Athery, Lombard, Patterson Park

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

D44187

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bayview Hospital ST. 26 WARD)

2-FULL NAME

Minnie Martinet

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

Unknown

ST.

WARD.

(if nonresident give city or town and State)

Don't know ds.

How long in U. S., if of foreign birth?

Don't know ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofDon't know

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.76✓✓

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)France

10 NAME OF FATHER

Henry Kimman

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

(Address)

Hospital RecordsBayview Hospital

15

File

JUN 22 1920ROBERT A. LEAUTEPublic Health Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 20 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 5, 1920, to June 20, 1920,that I last saw her alive on June 20, 1920,and that death occurred, on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) yrs. 4 mos. ds.CONTRIBUTORY
(Secondary)Acute Myocardial Insufficiency(duration) yrs. mos. 4 ds.18 Where was disease contracted
if not at place of death?Don't know

Did an operation precede death?

No Date of ✓

Was there an autopsy?

No

What test confirmed diagnosis?

Tubercle Bacilli in Sputum

(Signed)

Geo. R. Williams, M. D.

, 19

(Address)

Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Catholic CemeteryJune 22 1920

20 UNDERTAKER

Martin Luther1827 N. North

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

N. B.-Every item of information should be carefully supplied. AGE should be in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D44185

HEALTH DEPARTMENT--CITY OF BALTIMORE

D44185

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1416 E. Preston St.

ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E. Scott.

(Residence in Baltimore: No. 1416 E. Preston St. St.; 48 yrs. 10 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow.

6-DATE OF BIRTH August 9th. 1871 (Month) (Day) (Year)

7-AGE 48 yrs. 10 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work None. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore, Md.

10-NAME OF FATHER Joseph Elliott.

11-BIRTHPLACE OF FATHER (State or country) Ireland

12-MAIDEN NAME OF MOTHER Elizabeth Kehoe.

13-BIRTHPLACE OF MOTHER (State or country) Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Scott. (son)

(Address) 1416 E. Preston St.

JUN 22 1920

Filed 191

BOBBY A. ELLAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 21st. 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 9th. 1920, to June 21st. 1920.

that I saw her alive on June 20th. 1920.

and that death occurred, on the date stated above, at 1.30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration) yrs. 12 mos. ds.

Contributory Exhaustion (SECONDARY)

(Signed) Otto M. Reinhardt M. D.

June 21st. 1920 (Address) 1917 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathedral Bury June 23, 1920

20-IDENTITY

ADDRESS

Chas. F. Evanson 118 W. Mt. Royal Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44186

D44186

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1832 E 28th ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs. Augusta Heckelman

(a) RESIDENCE. NO.

1832 E 28th

ST.: 9

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds.

How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female, white

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Geo. Heckelman

6 DATE OF BIRTH (month, day, and year)

1860, Aug. 20

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

59

10

0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

1836

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Mr. Biscador Heckelman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mr. Margaret Heckelman 1832 E 28th St

15

Filed

JUN 22 1920

ROBERT I. LAUTER
Registrar

Barial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 20 1920

17

I HEREBY CERTIFY, That I attended deceased from November 1919, to June 20 1920, that I last saw her alive on June 20 1920, and that death occurred, on the date stated above, at 12:30 noon.

The CAUSE OF DEATH* was as follows:

Heart dilatation of heart

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

Consumption of alcohol

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. J. Zimmerman M. D.

, 19 (Address) 2850 Maryland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Lawn Cem

June 23 1920

20 UNDERTAKER

J. Herwig & Co

ADDRESS

2008 Wilkes

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44187

CERTIFICATE OF DEATH.

109 D44187

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

319 S. Norris Alley

ST.: 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary Selina

(Residence in Baltimore: No.

319 S. Norris Alley

St.: yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE.

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH.

Nov 21, 1910

7-AGE.

7 yrs., 7 mos., ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Loya Selina

11-BIRTHPLACE OF FATHER (State or Country),

Serbia

12-MAIDEN NAME OF MOTHER

Lena Rushin

13-BIRTHPLACE OF MOTHER (State or Country),

Serbia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lena Selina

(Address)

319 S. Norris Alley

15-

JUN 22 1920 ROBERT E. KRAUTER

Filed

191

ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 22, 1920

17- I HEREBY CERTIFY, That I attended deceased from June 22 1920, to June 22 1920, that I saw her alive on June 22 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Intussusception

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Collapse

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

June 23, 1920 (Address) 2576 Penn. av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Loudon Park

DATE OF BURIAL.

June 22, 1920

20-UNDERTAKER

Harry H. Metzger

ADDRESS

1531 W. Lombard

CAUSE OF DEATH—See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44188

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1112 N Port St.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1112 N Port St.

St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

May 5, 1882
(Month) (Day) (Year)

7-AGE,

38 yrs., 1 mos., 15 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

PARENTS.

10-NAME OF FATHER,

Arrested Nelson

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Carmelia Manges

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Rolt A. Elliott

(Address)

1725 Ashland Ave.

15-

Filed

JUN 22 1920

ROBERT E. ELAUTE

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 1, 1920, to June 20, 1920,

that I saw him alive on June 20, 1920,

and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease
(Duration) 1 yrs., 1 mos., 1 ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs., 1 mos., 1 ds.

(Signed)

June 21, 1920 (Address) 1301 N. Port St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Amelia Court House June 22, 1920

20-UNDERTAKER

Mrs R. A. Elliott Address 1725 Ashland Ave.

CAUSE OF DEATH in plain terms important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44189

CERTIFICATE OF DEATH.

103 D44189

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 N. Dallen ST.; 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 127 N. Dallen St.; 5 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX. Male	4-COLOR OR RACE. col.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) widowed
6-DATE OF BIRTH. ? ? ? (Month) (Day) (Year)		
7-AGE. 40 yrs. yrs. mos. ds.	If LESS than 1 day, ...hrs. or...min.?	
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE. (State or Country),		

PARENTS.	10-NAME OF FATHER. William Dallen
	11-BIRTHPLACE OF FATHER (State or Country). Worcester, Mass.
	12-MAIDEN NAME OF MOTHER Harriett Ann Wilson
	13-BIRTHPLACE OF MOTHER (State or Country). Worcester, Mass.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Dutton
(Address) 184 Preston St.15- JUN 22 1920 ROBERT R. KEAUTER
Filed 191. 201

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased about 9 weeks, to 191, that I saw him alive on 18 June 1920, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

The patient had suffered from attack of acute indigestion June 7, 1920, and died about two hours later.
(Duration) about two hours

CONTRIBUTORY (Secondary) Cordial Arrhythmia

(Signed) E. L. Hayfield, M. D.

2.1/6, 1920 (Address) 425 N. Dallen St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Ashbury Cemetery

DATE OF BURIAL,

June 22, 1920

20-UNDERTAKER

Mrs. H. A. Elliott

ADDRESS

1725- Ashland

important. See instructions on back of certificate.

D44190

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44190

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4*)ST.: *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *2*

(Usual place of abode)

ST. *4*WARD. *4*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb. 1870

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*50**7**7*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Johnna Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

*J. K. Reynolds**303. Canale Rd Roland Park*

15

JUN 22 1920

ROBERT

AUTER Registrar

Serial

Client

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 20 1920

17

I HEREBY CERTIFY, That I attended deceased from

*6/14 1920 to 6/20 1920*that I last saw him alive on *6/14*, 19*20*and that death occurred, on the date stated above, at *8:30 p. m.*

The CAUSE OF DEATH* was as follows:

General Abdominal Cancer
Obese

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *6/20*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Swan S. Reddy* M. D.1920 (Address) *1009 N. York St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Lowell Corp.**502 E. North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

D44191

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2502

CITY OF BALTIMORE: (No.

Calvert

ST. 12th WARD)

2-FULL NAME

George Washington Horton

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

2502 Calvert

ST. 12th WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

74 yrs.

mos.

6 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

Elizabeth F. Montgomery

6 DATE OF BIRTH (month, day, and year)

14 June 1846

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Chief-Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

Fire Dept.

(c) Name of employer

Baltimore City

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Peter Horton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant

Miss Mary Horton

(Address)

2502 Calvert St

15

FILED

JUN 22 1920

ROBERT E. KALJTER

Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 20 1920

17

HEREBY CERTIFY, That I attended deceased from

1 June 1920, to 20 June 1920,

that I last saw him alive on 20 June 1920.

and that death occurred, on the date stated above, at 8:20 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Chronic Interstitial Nephritis

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Phys Exam. Urinalysis

(Signed)

Barth T. Baggott M. D.

, 19

(Address) 1207 Mosher St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery

June 23 1920

20 UNDERTAKER

ADDRESS

Chas. G. Black 742 W. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *446 S Ann* ST.: *V* WARD)2-FULL NAME *Frank S Stachowski*(a) RESIDENCE. No. *446 S Ann* ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*White*5 Single, Married, Widowed,
or Divorced (write the word)*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Dec 24/1918*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*1**6**21*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*None. 000*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Balti Md.*

10 NAME OF FATHER

*F Stachowski*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Poland*

12 MAIDEN NAME OF MOTHER

*Regina Oleksik*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Poland*

14

Informant
(Address)*F Stachowski
446 S Ann St*

15

Filed

*JUN 22 1920*ROBERT H. KRAUTER
Registrar
Burial Permit Office

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)ST.: *V* WARD

ST.: WARD.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 22 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*June 16 1920 to June 21 1920*that I last saw him alive on *June 21 1920*and that death occurred, on the date stated above, at *5 A* m.

The CAUSE OF DEATH* was as follows:

Enterocolitis(duration) yrs. mos. *1* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Geo S Dwyer* M. D., 19 (Address) *2818 E Balto St**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Rovers**6/23 1920*

20 UNDERTAKER

ADDRESS

Wm Hallworth 1618 E. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44193

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Umanus Hospital* ST. *27* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Helen Bowen*(Residence in Baltimore: No. *Rappling - (Belair Road)* St.; *5* yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, DIVORCED, OR WIDOWED. *Single* (Write the word.)6-DATE OF BIRTH, *Don't know*, *1* (Month) (Day) (Year)7-AGE, *alt 40* yrs., mos., ds. If LESS than 1 day, hrs. or min.8-OCCUPATION: (a) Trade, profession, or particular kind of work. *alt Home 086* (b) General nature of industry, business, or establishment in which employed (or employer). *Umanus Hospital*9-BIRTHPLACE, (State or Country), *Virginia*10-NAME OF FATHER, *Capt. Bowen*11-BIRTHPLACE OF FATHER (State or Country), *Va.*12-MAIDEN NAME OF MOTHER *Mattha Holligsworth*13-BIRTHPLACE OF MOTHER (State or Country), *Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rev. R. L. Wood*(Address) *Rappling, Balto Co Md.*15- *JUN 22 1920* Robert P. Harrison, Registrar.

Burial Permit Clerk.

Via B & O. R.R. - 90 mi. C. L. Wood

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 21*, *1920*. (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 13 1920*, to *June 21 1920*, that I saw her alive on *June 21 1920*, and that death occurred, on the date stated above, at *11:40 p.m.*

The CAUSE OF DEATH was as follows:

Lobar Pneumonia (Duration) *8* yrs., *3* mos., *3* ds.CONTRIBUTORY (Secondary) *Myocardial Infarction*(Signed) *James S. Speed* M. D. *June 21 1920* (Address) *Umanus Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of death *2* yrs., mos., ds. In the State *Georgia* yrs., mos., ds.Where was disease contracted, if not at place of death? *Umanus Hospital*Former or usual residence *Atlanta Georgia*19-PLACE OF BURIAL OR REMOVAL, *Winchester - Federal Co. Va.* DATE OF BURIAL, *June 23, 1920*20-UNDERTAKER *William Cook* ADDRESS *502 E. North*

D14191

HEALTH DEPARTMENT—CITY OF BALTIMORE

D14191

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1817 Park Ave ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph A. Prudhomme(Residence in Baltimore: No. 1817 Park Ave St.; 20 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

male

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) married

6-DATE OF BIRTH,

March 19, 1841
(Month) (Day) (Year)

7-AGE,

71 yrs., 3 mos., 2 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Retired Cotton Planter
086

9-BIRTHPLACE, (State or Country),

Louisiana

10-NAME OF FATHER,

Louis Prudhomme

11-BIRTHPLACE OF FATHER (State or Country),

Louisiana

12-MAIDEN NAME OF MOTHER

Marie A. Prudhomme

13-BIRTHPLACE OF MOTHER (State or Country),

Louisiana

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Dr. Joseph A. Prudhomme
Chesmont Md

(Address)

15-

Filed

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 21, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Jan 1916, to June 21 1920, that I saw him alive on June 21 1920, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Acute Circulatory Failure
(Sudden)

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Ch. Pyelo-nephritis... 3 or 4 yrs.
hypertension & sclerosis
(Duration) yrs. mos. ds.(Signed) S. Carroll Lockhart M. D.June 22, 1920 (Address) 421 P. Street S.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral Cemetery

DATE OF BURIAL,

June 23 1920

20-UNDERTAKER

Chas G. Black 74 E. North Ave

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44195

D44195

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 12-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

JUN 22 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 22 1920

17

I HEREBY CERTIFY, That I attended deceased from June 20, 1920, to June 22, 1920, that I last saw him alive on June 21, 1920,

and that death occurred, on the date stated above, at 2. a. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

CONTRIBUTORY (Secondary)

Premature Birth

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. C. M. C. M. C. M. D.

(Address) 839 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Annapolis Maryland

June 23 1920

20 UNDERTAKER

Jas. S. Taylor Sons

ADDRESS

Annapolis Md

D44196

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44196

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 S. Becker Ave. ST.: 1 WARD)

2-FULL NAME

Alice M. Lambdin

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

523 S. Becker Ave ST.: 1 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Peter T. Lambdin

6 DATE OF BIRTH (month, day, and year)

Feb. 7, 1885

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.35417

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Work.

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Balto. Md.

10 NAME OF FATHER

John T. Jordan11 BIRTHPLACE OF FATHER (city or town)
(State or country)Balto. Md.

12 MAIDEN NAME OF MOTHER

Kannah Ortlip13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Port Deposit
Md.

14

Informant

Peter T. Lambdin

(Address)

523 S. Becker Ave.Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19th 1920

17

I HEREBY CERTIFY, That I attended deceased from

1 May 1920, to 19 June 1920,that I last saw her alive on 19 June 1920,and that death occurred, on the date stated above, at 645 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction(duration) yrs. mos. 21 ds.CONTRIBUTORY
(Secondary)Intestinal Peritonitis(duration) yrs. mos. 77 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 3 May 20Was there an autopsy? noWhat test confirmed diagnosis? Examination of abdomen & fluid.(Signed) W. T. Moore M. D.19 (Address) 301 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Lawn CemeteryJune 23rd 1920

20 UNDERTAKER

ADDRESS

Lilly & Zeller4038 Wolfe St.

JUN 22 1920

D44107

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44107

CERTIFICATE OF DEATH.

x 55

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* T. 7

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Rockwell Davis*(a) RESIDENCE. NO. *Rocky Mountain, N. C.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *1* mos. *24* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Caucasian* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Elysa Davis* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *July 15-1885*7 AGE *35* Years *11* Months *5* Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Acc. Co.*(b) General nature of industry, business, or establishment in which employed (or employer) *086*

(c) Name of employer

9 BIRTHPLACE (city or town) *S. C.* (State or country)10 NAME OF FATHER *Beverly Davis*11 BIRTHPLACE OF FATHER (city or town) *S. C.* (State or country)12 MAIDEN NAME OF MOTHER *Elysa Nelson*13 BIRTHPLACE OF MOTHER (city or town) *S. C.* (State or country)14 Informant *Hospital Record* (Address) *J. H. H.*15 Filed *Robert P. Harrison* Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 20 1920*

17

I HEREBY CERTIFY, That I attended deceased from *April 27*, 19*20* to *June 20*, 19*20*, that I last saw him alive on *June 20*, 19*20*, and that death occurred, on the date stated above, at *12.50 P.M.*

The CAUSE OF DEATH* was as follows:

Encephalitis lethargica(duration) yrs. *2* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Chas. Bloomfield*, M. D., 19*20* Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Marble Hill Funeral Co. S.C.**6/22 1920*

20 UNDERTAKER

ADDRESS

*Samuel T. Hensley**578 W. B. St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

JUN 22 1920

D44348

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44198

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MRS LYDIE M. HEPBURN(a) RESIDENCE. NO. Hotel Roanoke Roanoke ST. Va. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) MARRIED5a If married, widowed, or divorced HUSBAND of (or) WIFE of CAPT. CHARLES A. HEPBURN6 DATE OF BIRTH (month, day, and year) April 25 18907 AGE Years 50 Months 1 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HOTEL MANAGER

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) PA. (State or country)10 NAME OF FATHER John L. Mower11 BIRTHPLACE OF FATHER (city or town) Pa. (State or country)12 MAIDEN NAME OF MOTHER Sarah Warner13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)14 Informant J. H. H. Records (Address)15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-22 192017 I HEREBY CERTIFY, That I attended deceased from JUNE 5, 1920, to JUNE 22, 1920, that I last saw her alive on JUNE 22, 1920, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Bacterial PneumoniaSyphilis (duration) 1 yrs. 10 mos. 20 ds.CONTRIBUTORY Asphyxial poisoning (Secondary) (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? YES

What test confirmed diagnosis?

(Signed) Wm S. Tillett, M. D.6/22, 1920 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Belmar N. J. June 23 1920

20 UNDERTAKER ADDRESS

Robt Turner 1424

Information should be carefully supplied, and should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

JUN 22 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44109

D44109

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1737 Orleans ST.; 6 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. Baldwin Balto. County St.; 27 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

June 20, 1883
(Month) (Day) (Year)

7-AGE,

37If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Housewife

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Burial Permit C1011

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 20, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 16 1920, to June 20 1920, that I saw her alive on June 20th 1920, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis(Duration)....yrs....2 mos....1 ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....15 mos....15 ds.(Signed).....Dr. Frank J. Smith M. D.June 22, 1920 (Address).....384 W. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Baldwin Station Balto Co

DATE OF BURIAL

June 23, 1920.

20-UNDERTAKER

Charles H. Holland

ADDRESS

1631 Grand Hill

CAUSE OF DEATH in plain terms, so that it may be properly understood, important. See instructions on back of certificate.

JUN 22 1920

D44200

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44200

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on and that death occurred, on the date stated above, at 11:50 A.M.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence Scranton Pa

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

JUN 22 1920

D44201

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44201

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1400 Pennsylvania Ave. ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Nutter.(a) RESIDENCE. No. 1400 Penna. ave.

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1, 18857 AGE Years 25 Months 2 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md10 NAME OF FATHER Edmund Nutter11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md12 MAIDEN NAME OF MOTHER Ella Hottes13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md14 Informant Edmund Nutter(Address) 1400 Penna. av15 June 22 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 192017 I HEREBY CERTIFY, That I attended deceased from May 1 1920, 1919, to June 21 1920, 1919, that I last saw her alive on June 20 1920, 1919, and that death occurred, on the date stated above, at 4.30 A. M.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis.(duration) 4 yrs. mos. ds.CONTRIBUTORY Exhaustion. (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.What test confirmed diagnosis? Clinical.(Signed) Chas. F. Bente, M. D.6/21/1920 (Address) 1504 McCallion st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Landon ParkJune 23 1920

20 UNDERTAKER

ADDRESS

Geo W Little531 N Fremont

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D44202

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44202

2. CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1320 Mount

ST. 19

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 1320 Mount

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

14 yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Cbl

5 Single, Married, Widowed,
or Divorced (write the word)

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Lillian Dwyer

6 DATE OF BIRTH (month, day, and year)

Mar 17, 1884

7 AGE

Years

Months

Days

if LESS than
1 day, hrs.
or min.

36

36

3

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Post Off. employee

(b) General nature of industry,
business, or establishment in
which employed (or employer)

U.S. Government

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Orange Co. Va.

10 NAME OF FATHER

Frank Dwyer

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Orange Co. Va.

12 MAIDEN NAME OF MOTHER

Berrie Howard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Orange Co. Va.

14 Informant
(Address)Lillian Dwyer
1320 Mount St.

15

JUN 23, 1920

ROBERT E. ERAUTEE

Registrar
Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 21, 1920

17 I HEREBY CERTIFY, That I attended deceased from

June 9, 1920, to June 20, 1920.

That I last saw him alive on June 20, 1920.

and that death occurred, on the date stated above, at 10:50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Phthisis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. G. G. M. D.

6-2219 2 (Address) 1534 - 24th Ave.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Caringhill Co. 9th June 29, 1920

20 UNDERTAKER

JAMES H. DENNIS

1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 Samley St ST.: 6 WARD)

2-FULL NAME

Greenbury Johnson

(a) RESIDENCE

1906 Samley St

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

11

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasian5 Single, Married, Widowed,
or Divorced (write the word)Single

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

July 6

6 DATE OF BIRTH (month, day, and year)

1919 July 6

7 AGE

11

Months

Days

If LESS than

1 day, hrs.

or min.

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workNone(b) General nature of industry,
business, or establishment in
which employed (or employer)None

(c) Name of employer

None9 BIRTHPLACE (city or town)
(State or country)born in Baltimore

10 NAME OF FATHER

Greenfield Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Co

12 MAIDEN NAME OF MOTHER

Gertrude Halsted

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore County

14

Informant

(Address)

G. Greenfield Johnson1906 Samley St

15

JUN 23 1920

ROBERT KRAUTER

Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 21 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 19, 1920, to June 21, 1920,that I last saw him alive on June 21, 1920,and that death occurred, on the date stated above, at 11:10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia+ Marasmus

(duration)

yrs.

mos.

3

ds.

CONTRIBUTORY
(Secondary)Broncho Pneumonia

(duration)

yrs.

mos.

4

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Dr. J. W. Kennard

M. D.

221920 Address

708 Ensor St*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Usbury CemeteryJune 23 1920

20 UNDERTAKER

Mrs. A. A. Elliott

ADDRESS

1725 Ashland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44204

CERTIFICATE OF DEATH

9

D44204

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

Sydenham Hospital 26
Thomas Amend.
3230 Fair Ave.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 1 yrs. 11 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

male

4-COLOR OR RACE

white

5-SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

single.

6-DATE OF BIRTH

July 1, 1918
(Month) (Day) (Year)

7-AGE

1 yrs. 11 mos. 22 ds.

If LESS than
1 day, --- hrs.
or --- min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

none.

9-BIRTHPLACE
(State or country)

Uld.

10-NAME OF FATHER

William Amend.

11-BIRTHPLACE OF FATHER
(State or country)

Uld.

12-MAIDEN NAME OF MOTHER

Elizabeth Dougherty

13-BIRTHPLACE OF MOTHER
(State or country)

Uld.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. J. Amend

(Address)

3230 Fair Ave

15

Filed

JUN 23 1920

ROBERT H. KRAUTER

Bureau Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 22, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 21, 1920, to June 22, 1920

that I saw him live on June 22, 1920

and that death occurred, on the date stated above, at 1:30 P.m.

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria.

(Duration) --- yrs. --- mos. 5 ds

Contributory
(SECONDARY)

none.

(Duration) --- yrs. --- mos. --- ds.

(Signed)

Birkhead Magowan M. D.

June 22, 1920 (Address) Sydenham Hosp.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death --- yrs. --- mos. 1 ds. In the State --- yrs. --- mos. --- ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

at home

19-PLACE OF BURIAL OR REMOVAL

Sacred Heart Am.

20-UNDERTAKER

Lilly Geo Ziller

DATE OF BURIAL

June 23, 1920

ADDRESS

403 S. Wolcott

D44205

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

D44205

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(n) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Folio

JUN 23 1920

ROBERT A. KRAUTER Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from June 18, 1920, to June 21, 1920, that I last saw him alive on June 21, 1920, and that death occurred, on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

Left Lobar pneumonia; mitral insufficiency;

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Respiratory paralysis (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel P. Blayden, M. D.

19 (Address) S. E. Agnew Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Olivet Cemetery

June 23 1920

20 UNDERTAKER

ADDRESS

Harry H. Amason 4204 Ridgewood Ave

CAUSE OF DEATH in plain terms, so that it may be properly transcribed. See instructions on back of certificates.

D44206

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D44206

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Int. St. Agnes College* ST. *25* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs.

mos.

ds.

How long in U. S., if of foreign birth? *50* yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*78*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

JUN 23 1920

ROBERT A. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 22 1920*

17

I HEREBY CERTIFY, That I attended deceased from
March 1, 19*20*, to *June 22*, 19*20*.that I last saw him alive on *June 22*, 19*20*.and that death occurred, on the date stated above, at *7.40 P.M.*

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage(duration) yrs. mos. *3* ds.CONTRIBUTORY
(Secondary)(duration) *10* yrs. mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Ernest E. Keagan, M. D.Spr. 1920 (Address) *2438 Eutaw Place*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Agnes Convent**June 24 1920*

20 UNDERTAKER

ADDRESS

Henry Jenkins & Sons

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Mr V. 1109-10.30 m
Spec. - 6-9-19 - H. P. Co. - 1000 Bks.

144207

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 N. Durham St. ST.: 7 WARD)

2-FULL NAME

Charles A. Collins

(a) RESIDENCE, NO.

1022 N. Durham St. ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

Mabel Collins

6 DATE OF BIRTH (month, day, and year)

June 18, 1920

7 AGE

26

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

Newspaper

(c) Name of employer

A.A. American

9 BIRTHPLACE (city or town) (State or country)

Baltimore City

10 NAME OF FATHER

Charles Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Gertrude Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant

Gertrude Johnson

(Address)

1022 N. Durham St.

15

Filed

JUN 23 1920

ROBERT A. KRAUTER

Registrar

BRIAL PERMIT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 21 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 18, 1920, to June 21, 1920

that I last saw him alive on June 21, 1920

and that death occurred, on the date stated above, at 12:10 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy & Bright Disease
No complications

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Bright Disease

Complications (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. G. W. Kernand M. D.

6-21-20 Address 708 Euseb St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel

June 24 1920

20 UNDERTAKER

John W. Henderson

ADDRESS

1502 E. Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS SHOULD STATE EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1900 Ills.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44208

D44208

CERTIFICATE OF DEATH.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH CITY OF BALTIMORE: (No. 409 McAllister St. 17 WARD)

2-FULL NAME John Walter Gallen

(a) RESIDENCE. No. 409 McAllister St. WARD. (If nonresident give city or town and State)

(Usual place of abode) Length of residence in city or town where death occurred 29 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Ol 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Gallen

6 DATE OF BIRTH (month, day, and year) Jan. 20, 1891

7 AGE Years 29 Months 5 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Laborer (b) General nature of industry, business, or establishment in which employed Working in cement. (c) Name of employer The Penn. Mar. Cement Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore - Md.

10 NAME OF FATHER Leharus Gallen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore - Md.

12 MAIDEN NAME OF MOTHER Rebecca Summers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore - Md.

14 Informant (Address) Rebecca Gallen 409 McAllister St.

15 JUN 23 1920 ROBERT F. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1920

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1920, to June 20, 1920, that I last saw him alive on June 20, 1920, and that death occurred, on the date stated above, at 10-30 a.m.

The CAUSE OF DEATH* was as follows: Organic Heart Disease, Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex. (Signed) P. H. L. M. D.

22 1920 Address 1534 - V. H. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grand Cemetery DATE OF BURIAL Jan 14 1920

20 UNDERTAKER Chris C. Bulley ADDRESS 14 1/2 Jefferson St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44209

D44209

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 428 N. Spring ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Jettaphine Offard

(a) RESIDENCE

NO. 428 N. Spring ST., 5 WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Caucas 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Chas. H. Offard6 DATE OF BIRTH (month, day, and year) Unknown7 AGE Years 38 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balti.
(State or country) Md.10 NAME OF FATHER Thomas Dodd.11 BIRTHPLACE OF FATHER (city or town) Balti.
(State or country) Md.12 MAIDEN NAME OF MOTHER Jettaphine Trusty13 BIRTHPLACE OF MOTHER (city or town) Balti.
(State or country) Md.

PARENTS

14 Informant
(Address) Chas. H. Offard.
428 N. Spring St.

15

JUN 23 1920

ROBERT B. ERAUER Registrar

BRIEF EXHIBIT CLERK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 192017 I HEREBY CERTIFY, That I attended deceased from April 6, 1920, to June 21, 1920, that I last saw him alive on June 21, 1920, and that death occurred, on the date stated above, at 3-25 P. M.
The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease
(duration) 3 yrs. 0 mos. 0 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.6-22-1920 (Address) 120 1/2 Airgirth St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Ashbury CemeteryJune 23, 1920

20 UNDERTAKER

Chas. E. Bailey

ADDRESS

1421Jefferson St.

044210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

044210

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1145 N. Stricker ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Bertie Black(a) RESIDENCE. No. 1145 N. Stricker ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7 1880

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

40515

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sales lady

(b) General nature of industry, business, or establishment in which employed (or employer)

Dept. Store

(c) Name of employer

Excelsior Undergarment Store9 BIRTHPLACE (city or town) Westminster
(State or country) md.

10 NAME OF FATHER

John H. Black11 BIRTHPLACE OF FATHER (city or town)
(State or country)Westminster
Maryland

12 MAIDEN NAME OF MOTHER

Ann E. Clark13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Westminster
Maryland

14

Informant

(Address)

Hammond H. Black1145 N. Stricker St

15

JUN 23 1920BOBERT A. KLAVER
Registrar
Bureau of Health, City of Baltimore

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 19 20

17

I HEREBY CERTIFY, That I attended deceased from

June 20 19 20, to June 22 19 20that I last saw her alive on June 21 19 20and that death occurred, on the date stated above, at 1:05 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chr. Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

James Brown M. D.

6/23 1920 Address)

1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Westminster Rd June 25 1920

20 UNDERTAKER

ADDRESS

Geo W Little 531 St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

D44241 OF DEATH

CITY OF BALTIMORE: (No. 214 Richmond ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Melvin Smith(Residence in Baltimore: No. 214 Richmond St.; yrs., 6 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single (Write the word)6-DATE OF BIRTH. Dec 2 1919 (Month) (Day) (Year)7-AGE, yrs. 6 mos. 20 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.10-NAME OF FATHER, Charles Smith11-BIRTHPLACE OF FATHER (State or Country), Md.12-MAIDEN NAME OF MOTHER Marie E. Hawkins13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Smith(Address) 214 Richmond St.15- ROBERT H. BRAUTERFiled JUN 23 1920 191-Serial-Permit-Stamp-Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 22 1920 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 10 1919 to June 22 1919 that I saw him alive on June 21 1919 and that death occurred, on the date stated above, at 6 A.M. The CAUSE OF DEATH* was as follows: Bacterial enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia(Signed) A. L. Ellis M. D. June 22, 1920. (Address) 924 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, 2nd Auburn Emph DATE OF BURIAL, June 24 192020-UNDERTAKER George H. Holland ADDRESS 1631 40th Hillman

N. B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death important. See instructions on back of certificate.

186
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D44213

CERTIFICATE OF DEATH

31 D44213

REGISTERED No. C

PLACE OF DEATH 1121 W. Franklin St.

CITY OF BALTIMORE (No. _____)

ST. 18 WARD)

2-FULL NAME Nora R. Duggan

(Residence in Baltimore: No. 1121 W. Franklin St.)

20 yrs. 7 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6-DATE OF BIRTH March 15, 1855 (Month) (Day) (Year)

7-AGE 65 yrs. 3 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Housewife 037

9-BIRTHPLACE (State or country) Richmond Va

PARENTS 10-NAME OF FATHER Michael McCann 11-BIRTHPLACE OF FATHER (State or country) Cork Ireland 12-MAIDEN NAME OF MOTHER Johanna Mahoney 13-BIRTHPLACE OF MOTHER (State or country) Cork Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Marie G. Duggan (Address) 1121 W. Franklin St.

15. JUN 23 1920 ROBERT F. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 21, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 20, 1920 to June 21, 1920 that I saw her alive on June 20, 1920 and that death occurred, on the date stated above, at 6:30 a. m. The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) 3 yrs. mos. ds. Contributory (SECONDARY) (Duration) 7 yrs. mos. ds. (Signed) Bernard Russell Mose M. D. June 21, 1920 (Address) 1039 Edmonson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL St Marys Gonaustown DATE OF BURIAL 6-23-1920

20-UNDERTAKER H. B. Haunig 504 ADDRESS 517 N. Schneider St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No New City HospitalST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie West(a) RESIDENCE. No. 938 Argyle Ave.
(Usual place of abode)

ST. _____ WARD. _____

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. _____ mos.

ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18507 AGE Years Months Days If LESS than
70 1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co., Md.
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14

Informant Hospital Records
(Address) New City Hospital.

15

JUN 23 1920 ROBERT F. LEAUTE
Registrar
Burial Permit 9111

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1920

17

I HEREBY CERTIFY, That I attended deceased from
June 5, 1920, to June 21, 1920,
that I last saw her alive on June 21, 1920,
and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis;(duration) _____ yrs. 67 mos. _____ ds.CONTRIBUTORY
(Secondary)(duration) ? yrs. _____ mos. _____ ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Urine + Blood(Signed) J. F. Pessell, M. D.June 21 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn6-25 1920

20 UNDERTAKER

ADDRESS 142John H. ToadumW. H. H. H.

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44212

D44212

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

945 S. Sharp

ST.:

23

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Vivia Gray

(a) RESIDENCE. NO.

945 S. Sharp

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female Colored Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 1869

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

37

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Cal. Co. Md

10 NAME OF FATHER

Major Gove

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Jane Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

James H. Hester 945 S. S. Sharp St

15

Filed JUN 23 1920

ROBERT E. LEAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 20 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 1, 1920, to June 20, 1920

that I last saw her alive on June 20, 1920

and that death occurred, on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemiplegia

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. 20 ds.

18 Where was disease contracted If not at place of death?

945 S. Sharp St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

J. H. Hester M. D. 712 S. Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn June 23 1920

20 UNDERTAKER

ADDRESS

John H. Toadon 142 W. Sharp St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D44215

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1139 S. Sharp St. ST. 23 WARD)

2-FULL NAME Estella Pack Noel. (C)

(Residence in Baltimore: No. 1139 S. Sharp St.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

36 5 28
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female. 4-COLOR OR RACE, Colored. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)

6-DATE OF BIRTH, December 25th, 1883, 1
(Month) (Day) (Year)

7-AGE, 36 yrs. 5 mos. 28 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, None.
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Isaac Johnson (C)

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER, Henrietta Wallace. (C)

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Isaac Noel. (C) husband.
(Address) 1139 S. Sharp St.

15-Filed JUN 23 1920 ROBERT A. KAUTER
Burial: FIVE CLAY

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 22nd, 1920, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry.
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(Duration)yrs.mos.ds.

CONTRIBUTORY (Secondary)yrs.mos.ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)
June 22, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of deathyrs.mos.ds. Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mancock Wicomico June 24 1920

20-UNDERTAKER, ADDRESS 142

John H. Treadwell

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44216

CERTIFICATE OF DEATH.

105 D44216
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *509 McMechen* ST.; *14* WARD)

2-FULL NAME

John Clarke Ellis

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *509 McMechen* St.; *1* yrs. *1* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*Colored*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Mar 15th 1917
(Month) (Day) (Year)

7-AGE,

3 yrs. *3* mos. *6* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....*None*9-BIRTHPLACE,
(State or Country),*Poloroda*10-NAME OF
FATHER,*John Ellis*11-BIRTHPLACE
OF FATHER
(State or Country),*N. C.*12-MAIDEN NAME
OF MOTHER*Rhetta Mason*13-BIRTHPLACE
OF MOTHER
(State or Country),*Pa*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Rhetta Ellis

(Address).....

509 McMechen St

15-

JUN 23 1920

ROBERT E. TRAUTER

191.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 22, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 22nd 1920, to *June 22 1920*,
that I saw him alive on *June 22 1920*,
and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH* was as follows:

Diarrhoea & Enteritis..... (Duration)..... yrs. mos. ds.
CONTRIBUTORY.....
(Secondary) *Chronic Gastritis*..... (Duration)..... yrs. mos. ds.
(Signed).....
Harry F. Brown M. D.
June 23rd 1920 (Address) *1501 Presman St**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-
SIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?.....Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn Cemty.

DATE OF BURIAL,

June 23, 1920

20-UNDERTAKER

Geo. H. Holland

ADDRESS

1631 David Hill

N. B.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH is important. See instructions on back of certificate.

N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44217

CERTIFICATE OF DEATH.

D44217

1-PLACE OF DEATH 2664 Florence ST. 13
CITY OF BALTIMORE (No. 13) WARD
2-FULL NAME Chas. F. Stimmel
(Residence in Baltimore: No. 2664 Florence.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

10 St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male
4-COLOR OR RACE White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married
6-DATE OF BIRTH, Oct 4, 1867
(Month) (Day) (Year)
7-AGE, 52 yrs. 8 mos. 17 ds.
If LESS than 1 day, ... hrs. or ... min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. City Employee
(b) General nature of industry, business, or establishment in which employed (or employer). Street Cleaners
9-BIRTHPLACE, (State or Country), Frederick Co
10-NAME OF FATHER, Cornelius Stimmel
11-BIRTHPLACE OF FATHER, Frederick Co
(State or Country)
12-MAIDEN NAME OF MOTHER, Ann Barthlo
13-BIRTHPLACE OF MOTHER, Md
(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank J. Kimmelman
(Address) 1736 Rd. North Ave

15-

JUN 23 1920

191

ROBERT A. KAUTER

DEATH CERTIFICATE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 22, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

THE CAUSE OF DEATH was as follows:

Valvular diseases of heart
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Morrison, M.D.
(Coroner.)

(Address) 7632 Roland Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Roudon Park Cemetery June 23, 1920

20-UNDERTAKER, ADDRESS

Wm. T. McKee, 1000 North & Pa

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D44218

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1010 Warner

ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ernest T. Broch

(A) RESIDENCE.

No. 1010 Warner

ST. 21 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

25 yrs. — mos.

ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of

Mary E. Broch

6 DATE OF BIRTH (month, day, and year)

March 2, 1865

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

55

3

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Metal Wk

(b) General nature of industry, business, or establishment in which employed (or employer)

Brass Works

(c) Name of employer

Self.

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Edw. Broch

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Angeli Hammerstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mary E. Broch 1010 Warner

15

JUN 23 1920

ROBERT E. LAUTER Registrar

Bariat Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 21 1920

I HEREBY CERTIFY That I attended deceased from

June 12, 1920 to June 21, 1920

that I last saw him live on June 21, 1920

and that death occurred, on the date stated above, at 6:10 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

John E. Schwenker M. D.

19

(Address) 1220 W. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cemetery

June 24 1920

20 UNDERTAKER

O. Schuman & Son

ADDRESS 1034

Baltimore

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44219

CERTIFICATE OF DEATH.

D44219

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

Muniment

ST.:

15

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Abraham Cohen

(Residence in Baltimore: No.

2114 Penna ave

St.:

28

yrs.,

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH.

Unknown

(Month)

(Day)

(Year)

7-AGE.

67

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE.
(State or Country),

Russia

10-NAME OF FATHER.

Jacob Cohen

11-BIRTHPLACE OF FATHER
(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Sarah Kushner

13-BIRTHPLACE OF MOTHER
(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Louis Cohen

(Address)

2114 Penna ave

15- JUN 23 1920

ROBERT E. KRAUTER

Filed....., 191..

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June

(Month)

22, 1920

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 16, 1920, to June 22, 1920,

that I saw him alive on June 22, 1920,

and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

Diabetic Coma

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

Benign Prostatic Hypertrophy

Diabetes

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

6-28-20, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

2114 Penna ave

19-PLACE OF BURIAL OR REMOVAL.

Hebrew Home for the Aged

DATE OF BURIAL.

June 23, 1920

20-UNDERTAKER

Max Gerson

ADDRESS

117 E Balto St

N.B.—Every item of information should be carefully checked, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D44220

HEALTH DEPARTMENT—CITY OF BALTIMORE

D41220

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 626 N. Eustaw St. 11

2-FULL NAME

William A. Reay

(Residence in Baltimore: No. 626 Eustaw St.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH,

unknown, 1861 (Month) (Day) (Year)

7-AGE,

59 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

musician (blind) 086

9-BIRTHPLACE, (State or Country),

unknown

PARENTS.

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER (State or Country),

unknown

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER (State or Country),

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Mary Deval

(Address)

626 Eustaw St.

15-

Robert P. Harrison,

191

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 22, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, au-

opsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. A. Hennessy M. D. (Coroner.)

June 22, 1920 (Address) 2802 Edgemoor Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Louder Park Cem

DATE OF BURIAL,

6-24, 1920

20-UNDERTAKER

Robert Brooks & Son

ADDRESS

17 S Calhoun st

JUN 23 1920

Baltimore, Md., July 8, 1920.

I do hereby make oath that the name of deceased given on
Baltimore City Health Department Certificate No. D-44220, as William A. Reay,
incorrect as is also the age given, 59 years; and that the correct name
William Mabury Reay, born January 1st, 1871, so that age should appear
said certificate as 49 years, instead of 59 years.

Oliver Burgett.
Nephew.

Subscribed and sworn to before me this 8th day of July, 1920.

Reed Guther.
Notary Public.

D44221

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44221

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 Hollins St.

ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Smith

(a) RESIDENCE. No. 1624 Hollins St.

ST. 19 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herbert Smith

6 DATE OF BIRTH (month, day, and year) Aug. 13, 1832

7 AGE Years 57 Months 9 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Thomas Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Miss Frye

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Herbert Smith (Address) 1624 Hollins St.

Robert F. Harrison,

19

Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1920 to June 22, 1920, that I last saw her alive on June 21, 1920, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows: Coronary Dilatation

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) yrs. mos. 3 ds. (duration) 4 mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James H. Katzenberger, M. D. 6/23, 1920 (Address) 1729 N. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL June 24, 1920

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Baltimore St.

ation should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 23 1920

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D44222

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

62 D44222

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1104 Hollins Street ST. 18 WARD)

2-FULL NAME

Mary Catherine Hollinger

(Residence in Baltimore: No. 1104 Hollins

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX female 4-COLOR OR RACE white 5-~~SINGLE~~ MARRIED married (Write the word)

6-DATE OF BIRTH April 9th, 1852 (Month) (Day) (Year)

7-AGE 68 2 13 If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Housework Home

9-BIRTHPLACE (State or country) Balto Md

10-NAME OF FATHER Andrew Jackson Mayhew

11-BIRTHPLACE OF FATHER Md

12-MAIDEN NAME OF MOTHER Mary Doocep

13-BIRTHPLACE OF MOTHER N.Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo B Hollinger (Address) 1104 Hollins St

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 22nd 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 29th 1918, to June 1920 that I saw her alive on June 18th 1920, and that death occurred, on the date stated above, at 12.15 m. The CAUSE OF DEATH* was as follows:

Locomotor ataxia

(Duration) 9 yrs. mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) F. W. Hartley-Melby M. D. June 22nd, 1920. (Address) 1204 W. Fayette St

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Woodlawn Cemt DATE OF BURIAL June 5th 1920

20-INTERURER ADDRESS 1723 W. Fayette Ave

JUN 23 1920 Robert P. Harrison, 191 REGISTRAR Burial Permit Clerk

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D44223

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44223

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *Annuried dead at Natl Hospital* ST. *175* WARD)

FULL NAME

Leonora D. Roberts

(Residence in Baltimore: No. *3607* *Garrison Ave*

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., — mos. *4* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Dec 31, 1865
(Month) (Day) (Year)

7-AGE,

54 yrs. *5* mos. *22* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

House wife

9-BIRTHPLACE, (State or Country),

Northampton Co Va

10-NAME OF FATHER,

John E Johnson

11-BIRTHPLACE OF FATHER (State or Country),

Northampton Co Va

12-MAIDEN NAME OF MOTHER

Mary Kellam

13-BIRTHPLACE OF MOTHER (State or Country),

Accomac Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *William T. Roberts*

(Address) *Birds Nest Va*

15-

Robert P. Harrison,

Burial Permit Clerk,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 22, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* *June 23 - 8:30 A.M.* (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said *inquest* *on the day stated above.*

And that said deceased came to *his* death *on the day stated above.*

The CAUSE OF DEATH* was as follows:

Fract. skull struck by auto mobile at target & Liberty June 22-1920
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.
(Signed) *W. H. Smith* M. D.
(Coroner.) *June 23, 1920* (Address) *1687 Bury*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence *Birds Nest Va*

19-PLACE OF BURIAL OR REMOVAL,

Birds Nest - Virginia

DATE OF BURIAL,

JUN. 23, 1920

20-UNDERTAKER

JOHN F. DENNY

ADDRESS

716 LIGHT ST.

D44224

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44224

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mrs. Woot.*ST.: *18* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Neal Coleman*(a) RESIDENCE. NO. *Chilin Corp., Schraden*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 22, 1914

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*8*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Balto. Md.*10 NAME OF FATHER *Harry W. Albright*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*B. Y.*12 MAIDEN NAME OF MOTHER *Pauline Coleman*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Balto. Md.*

14

Informant
(Address)*Pauline Coleman
1345 E. 1st St.*

15

Filed

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 23, 1920

17

I HEREBY CERTIFY, That I attended deceased from

*6/23, 1920, to 6/23, 1920,*that I last saw him alive on *6/23, 1920.*and that death occurred, on the date stated above, at *11 a. m.*

The CAUSE OF DEATH* was as follows:

Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?*Mrs. Woot. - Chilin Corp.*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Lucas J. R. R. R.* M. D.

6/23, 1920 (Address)

Mrs. Woot.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Marys Hospital June 24, 1920

20 UNDERTAKER

ADDRESS

Chenoweth Son Chestnut Ave

mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Extra statements should be stated on back of certificates. See instructions on back of certificates.

JUN 23 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

1144225

CERTIFICATE OF DEATH.

151 1144225
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2112 E. Lombard ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Uetto Wilmus(Residence in Baltimore: No. 2112 E. Lombard St.; yrs., mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

June 22, 1920
(Month) (Day) (Year)

7-AGE,

..... yrs. mos. ds.

If LESS than 1 day,

13 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),Balti Ind.

PARENTS.

10-NAME OF FATHER,

Cyril A. Wilmus11-BIRTHPLACE OF FATHER
(State or Country),Penna.

12-MAIDEN NAME OF MOTHER

Irene P. Kaul13-BIRTHPLACE OF MOTHER
(State or Country),Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Cyril A. Wilmus(Address) 2112 E. Lombard St

15-

JUN 24 1920

ROBERT H. KAUTER

Filed.....

191.....

BUTZ

FRIED

O'NEILL

REGISTRAR.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 22 1920, to June 23 1920,that I saw him alive on June 23 1920,and that death occurred, on the date stated above, at 1 P.m.

The CAUSE OF DEATH* was as follows:

Six months' mis carriage

(Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) Eugene P. Passano M. D.June 23 1920 (Address) 2319 E. Baltch

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Cem

DATE OF BURIAL,

June 24, 1920

20-UNDERTAKER

Lilly & Zeller

ADDRESS

4030 W. 1st St

N.B.—Every item of information should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44226

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)
Length of residence in city or town where death occurred

Yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the usual)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 29-1901

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

18

6

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Richard H. Allen

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Richard H. Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Don't know

12 MAIDEN NAME OF MOTHER

Josephine Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

14

Informant (Address)

Margie Lynde 1642 E. Monument St.

15

JUN 24 1920

ROBERT I. LEAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 20th 1920

17

I HEREBY CERTIFY, That I attended deceased from April 26th 1920 to June 20th 1920.

that I last saw him alive on June 18th 1920.

and that death occurred, on the date stated above, at 11:00 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Gravid

(duration) yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical Exam

(Signed) John H. Prater, M.D.

19 (Address) 1402 Jefferson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Auburn Ave June 24 1920

20 UNDERTAKER ADDRESS

Samuel S. Sweeney 5th St. Bldg.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44227

CERTIFICATE OF DEATH.

40 D44227

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 5 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret M. Maly

6 DATE OF BIRTH (month, day, and year) May 10/1867

7 AGE Years 52 Months 1 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer) Hingan Prov. Co.

(c) Name of employer Haldy Pleasant St.

9 BIRTHPLACE (city or town) County Cork (State or country) Ireland

10 NAME OF FATHER Daniel Maly

11 BIRTHPLACE OF FATHER (city or town) County Cork (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Conway

13 BIRTHPLACE OF MOTHER (city or town) County Cork (State or country) Ireland

14 Informant Mrs. Julie Fisher Houghton (Address) 1521 Wilkes St.

JUN 24 1920

ROBERT F. FRASTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1920, to June 23, 1920, that I last saw him alive on June 23, 1920, and that death occurred, on the date stated above, at 4 A. M. The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of April 1920

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

6-23, 1920 (Address) 120 1/2 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Cross Cemetery Harford Rd June 25 1920

20 UNDERTAKER ADDRESS

James W. Conklin 924 E. Eager St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S signature CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44228

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D44228

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 3408. Dillon ST.: 26 WARD)
2-FULL NAME Margaret Reiter
(a) RESIDENCE. No. 3408. Dillon ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS
3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of
6 DATE OF BIRTH (month, day, and year) 6. 23. 20
7 AGE Years Months Days If LESS than 1 day, 6 hrs. or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 600
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9 BIRTHPLACE (city or town) Baltimore (State or country) MD
10 NAME OF FATHER John Reiter
11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) MD
12 MAIDEN NAME OF MOTHER Emma McNamee
13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) MD

14 Informant John Reiter (Address) 3408. Dillon St
15 JUN 24 1920
ROBERT E. LEASTHER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH
16 DATE OF DEATH (month, day, and year) 6 23 1920
17 I HEREBY CERTIFY, That I attended deceased from 6 23, 1920, to 6 23, 1920, that I last saw her alive on 6 23, 1920, and that death occurred, on the date stated above, at 3:30 P. m.
The CAUSE OF DEATH* was as follows:
Premature Birth
7 months
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.
18 Where was disease contracted None if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
6 (Signed) W B Lillow, M. D.
23, 1920 (Address) 2921 Odome St
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Ch. DATE OF BURIAL June 24 1920
20 UNDERTAKER Lilly & Ziehl ADDRESS 403 S. N. Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44229

CERTIFICATE OF DEATH

D44229

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *Sydenham Hospital* ST. *2* WARD)
2-FULL NAME *James Szymanski*
(Residence in Baltimore: No. *322 S. Washington* St.: *1* yrs. *6* mos. *18* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *male* 4-COLOR OR RACE *white* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(If write the word)

6-DATE OF BIRTH
Dec (Month) *6* (Day) *1918* (Year)

7-AGE
1 yrs. *6* mos. *18* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country) *U.S.*

10-NAME OF FATHER *Vincent Szymanski*

11-BIRTHPLACE OF FATHER
(State or country) *Poland*

12-MAIDEN NAME OF MOTHER *Leokadia Lewandowska*

13-BIRTHPLACE OF MOTHER
(State or country) *Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Vincent Szymanski*

(Address:) *322 S. Washington*

15-*ROBERT E. ERAUTER*

Filed *JUN 24 1920* *Baltimore* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH
June (Month) *23* (Day) *1920* (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 21*, 19*20*, to *June 23*, 19*20* that I saw him alive on *June 23*, 19*20* and that death occurred, on the date stated above, at *8:25* pm. The CAUSE OF DEATH* was as follows:

Diphtheria, bronchial, tonsillar + laryngeal.
(Duration) yrs. mos. *5* ds.

Contributory (SECONDARY) *Bronchopneumonia*
(Duration) yrs. mos. *3* ds.

(Signed), *Billagowan* M. D.
June 24, 19*20* (Address) *Sydenham Hospital*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. *3* ds. In the State yrs. mos. ds.
Where was disease contracted, *at home*.
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Holy Rosary cemetery DATE OF BURIAL *June 24*, 19*20*

UNDERTAKER *John M. Weber* ADDRESS *1803 Bank St*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44230

D44230

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1711 N. Lexington St. 19

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Maryann Lewis

(Residence in Baltimore: No.

1711 N. Lexington

St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F

4-COLOR OR RACE,

N

5-STATUS,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Widowed

6-DATE OF BIRTH,

March 30, 1838
(Month) (Day) (Year)

7-AGE,

82 yrs. 4 mos. 2 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Pa

10-NAME OF FATHER,

Lewis McDonald

11-BIRTHPLACE OF FATHER
(State or Country),

Canada

12-MAIDEN NAME OF MOTHER

Catherine Olson

13-BIRTHPLACE OF MOTHER
(State or Country),

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. J. C. Young

(Address)

1711 N. Lexington St.

15-JUN 24 1920

ROBERT A. ERAUTER

Filed.....

191.....

BORIS PATENT REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 20, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

June 1, 1920, to June 20, 1920,

that I saw him alive on..... 191.....

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy
Cerebral Hemorrhage

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) Edward A. Morgan M. D.

June 20, 1920 (Address) 1322 N. E. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

June 23, 1920

20-UNDERTAKER

Josiah Syfer

ADDRESS

1601 N. North St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44231

CERTIFICATE OF DEATH.

150 D44231

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 Wellington ST.: 13 WARD)

2-FULL NAME

Infant of J. M. L. and Annie Knight

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

808 Wellington

ST., 13 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22-1920

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER

J. M. L. Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER

Annie McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14

Informant (Address)

J. M. L. Knight 808 Wellington St.

15

Filed JUN 24 1920

ROBERT E. KRAUTER

Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1920

17

I HEREBY CERTIFY, That I attended deceased from June 23, 1920, to June 24, 1920, that I last saw her alive on June 24, 1920, and that death occurred, on the date stated above, at 1:30 a. m. The CAUSE OF DEATH* was as follows:

Morbus Caeculeus (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. E. Rich M. D. 112 U. 25-45 X

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mary's Hospital

June 24 1920

20 UNDERTAKER

ADDRESS

Horace Burgee Son

603 Falls Rd.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Hks.

D44232

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 ✓ D44232

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1224 N. Dallas*)

ST.: *8*—WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary B. Myers*

(a) RESIDENCE. No. *1224 N. Dallas*

ST., *8*—WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

Mos.

ds. How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Wm. H. Myers

6 DATE OF BIRTH (month, day, and year) *Jan. 13, 1841*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

79

4

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.*
(State or country)

10 NAME OF FATHER *John Mitchell*

11 BIRTHPLACE OF FATHER (city or town) *Md.*
(State or country)

12 MAIDEN NAME OF MOTHER *Mollie Phillips* *6/23/1920* (Address) *1223 N. Caroline St.*

13 BIRTHPLACE OF MOTHER (city or town) *Md.*
(State or country)

14 Informant *Annie Rice*
(Address) *1000 N. Gay St.*

15 *ROBERT V. KAUTER*
Registrar

JUN 24 1920 *BALTIMORE*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 23, 1920*

17

I HEREBY CERTIFY, That I attended deceased from *June 14, 1920*, to *June 23, 1920*, that I last saw her alive on *June 23, 1920*, and that death occurred, on the date stated above, at *12 15 P. M.*
The CAUSE OF DEATH* was as follows:

Arterial sclerosis

(duration) *4* yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cerebral Apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *None*

(Signed) *Edwin B. Tenby*, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL DATE OF BURIAL

St. Christ Cem *Jun 20/20*

20 UNDERTAKER

William Cook

ADDRESS

114 E M

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

M. V. 5222

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044233

CERTIFICATE OF DEATH.

120 1044233

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Biedler-Sellman Sanatorium* ST.: *16* WARD)

2-FULL NAME

Everett John Dowell

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

(Usual place of abode)

6317 Calhoun

ST.,

WARD.

(*Resident*)

Length of residence in city or town where death occurred

50 yrs.

? mos.

? ds.

How long in U. S., if of foreign birth?

69 yrs.

4 mos.

18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Gelma L. Dowell

6 DATE OF BIRTH (month, day, and year)

Feb-5-1851

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

69

4

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

Building

(c) Name of employer

(Self)

9 BIRTHPLACE (city or town) (State or country)

Friendship A.A. Co Maryland

10 NAME OF FATHER

Charles Dowell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Friendship Maryland

12 MAIDEN NAME OF MOTHER

Sarah Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Friendship Maryland

14

Informant (Address)

Mr. E. Palmer Dowell—(Son) 6317 Calhoun St.

15

JUN 24 1920

ROBERT A. KAUTER

Registrar

Birth Permit 016

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 23* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

June 15, 19 *20*, to *June 23*, 19 *20*.

that I last saw him alive on *June 23*, 19 *20*.

and that death occurred, on the date stated above, at *7:30* a.m.

The CAUSE OF DEATH* was as follows:

Industrial Neglect

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Measles

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *June 29*

Was there an autopsy? *no*

What test confirmed diagnosis? *Cysticerci Stom.*

(Signed) *George E. Thomsen*, M. D.

, 19 (Address) *212 W. Madison St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cemetery

June 25 19 *20*

20 UNDERTAKER

STEWART & MOWEN COMPANY

WILLIAM F. WOODEN, Successor

ADDRESS

108 W. NORTH AVE.

PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1000 Bks. **D44234**

HEALTH DEPARTMENT—CITY OF BALTIMORE **D44234**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. **2033 Madison Ave.** ST. **14** WARD)

2-FULL NAME **Josephine Sylvesta Keenan**

(a) RESIDENCE. NO. **2033 Madison Ave** ST. **14** WARD. **(Resident)**

(Usual place of abode) Length of residence in city or town where death occurred **69** yrs. **6** mos. **10** ds. How long in U. S., if of foreign birth? **69** yrs. **6** mos. **10** ds.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Female** 4 COLOR OR RACE **White** 5 Single, Married, Widowed, or Divorced (write the word) **Single**

5a If married, widowed, or divorced HUSBAND of (or) WIFE of **(Single)**

6 DATE OF BIRTH (month, day, and year) **Dec-12-1850**

7 AGE Years **69** Months **6** Days **10** If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work **none**
(b) General nature of industry, business, or establishment in which employed (or employer) **none**
(c) Name of employer **none**

9 BIRTHPLACE (city or town) (State or country) **Baltimore Maryland**

10 NAME OF FATHER **James E. Keenan**

11 BIRTHPLACE OF FATHER (city or town) (State or country) **Ireland**

12 MAIDEN NAME OF MOTHER **Mary Murphy**

13 BIRTHPLACE OF MOTHER (city or town) (State or country) **Ireland**

14 Informant **Mrs. Mildred P. Taylor (sister)** (Address) **2033 Madison Ave**

15 Filed **JUN 24 1920** **ROBERT E. KEAULTEE** Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **June 22 1920**

7 I HEREBY CERTIFY, That I attended deceased from **June 20**, 1920, to **June 22**, 1920, that I last saw her alive on **June 22**, 1920, and that death occurred, on the date stated above, at **10 A.** m. The CAUSE OF DEATH* was as follows:

Dilatation of Heart (Aortic Stenosis)

(duration) yrs. **3** mos. **3** ds. CONTRIBUTORY **Aortic Stenosis** (Secondary) (duration) **3** yrs. **3** mos. **3** ds.

18 Where was disease contracted If not at place of death? **✓**

Did an operation precede death? **no** Date of **✓**

Was there an autopsy? **no**

What test confirmed diagnosis? (Signed) **Chas. C. Cole** M. D.

19 (Address) **2033 Madison Ave**

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Catholic Cemetery **June 25 1920**

20 UNDERTAKER **STEWART & MOWEN COMPANY** ADDRESS **108 W. NORTH AVE.** (WILLIAM F. WOODEN, Successor)

N. B.—WRITE PLAINLY, WITH CARE AND EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1900 Bks.

D44235

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44235

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *64. Kenwood Ave* ST. *6* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *64. Kenwood Ave* ST. *6* WARD. *6*

(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Murphy

6 DATE OF BIRTH (month, day, and year)

March 2nd 1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

72

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

John Scally

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Marian

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14 Informant (Address)

Kate Murphy
64 Kenwood Ave

15

JUN 24 1920

ROBERT H. BRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 22 1920

17

HEREBY CERTIFY, That I attended deceased from

June 15 1920 to *June 21 1920*

that I last saw him alive on *June 21 1920*

and that death occurred, on the date stated above, at *130 P* m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos. ds. *8*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Geo S. Dwyer*, M. D.

, 19 (Address) *2818 E. Balto*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cem

6/25/1920

20 UNDERTAKER

J. A. Moran

ADDRESS

2818 E. Balto

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44236

CERTIFICATE OF DEATH.

D44236

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 634 BradleyST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo Slaughter(a) RESIDENCE. NO. 634 Bradley

(Usual place of abode)

ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

10 mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 18 - 1919

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

10 - 4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md

10 NAME OF FATHER

Wm Slaughter

11 BIRTHPLACE OF FATHER (city or town)

Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER

Minnie Blockson

13 BIRTHPLACE OF MOTHER (city or town)

Balto Md

(State or country)

14

Informant (Address)

Minnie Blockson
634 Bradley

15

JUN 24 1920

ROBERT E. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 22 - 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 20, 1920 to June 22, 1920, that I last saw him alive on June 21, 1920.and that death occurred, on the date stated above, at 1255A m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

at place deathDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Justus Tolman M. D., 19 (Address) 656 N. Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Albans Church

20 UNDERTAKER

Amos E. Egan

N. B.—WRITE CAREFULLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH EXPANDING INK—THIS IS A DEED. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44237 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D44237

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 29 Haefor St ST.: 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. G. Barrer

(a) RESIDENCE. NO. 29 Haefor St ST. WARD.

(Usual place of abode) Length of residence in city or town where death occurred 73 yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? 73 yrs. 6 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George L. Barrer

6 DATE OF BIRTH (month, day, and year) June 12 1847 7 AGE Years 72 Months 6 Days 22

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer) at home (c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER Geo O Slamm

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or country)

12 MAIDEN NAME OF MOTHER Turner

13 BIRTHPLACE OF MOTHER (city or town) Hartford Co Md (State or country)

14 Informant Frank L. Barrer, Son (Address) 112 Grandview Ave Pk Rd

15 JUN 24 1920 ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb 5 1920, to June 23 1920, that I last saw her alive on June 22 1920, and that death occurred, on the date stated above, at 1:15 A.m.

The CAUSE OF DEATH* was as follows: Chronic Intestinal Pepsitis

CONTRIBUTORY (Secondary) (duration) 3 yrs. mos. ds. Chronic Pains (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of none

Was there an autopsy? No

What test confirmed diagnosis? Urinary Test

(Signed) Chas A. Hetherington M. D. (Address) 1807 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park 6/20/19

20 BURIALER Robert Brooks & Son Calhoun

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44238

CERTIFICATE OF DEATH.

170 D44238

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 S. Stricker St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Barton

(Residence in Baltimore: No. 106 S. Stricker St. 65 yrs. 8 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)
6-DATE OF BIRTH, Oct 3, 1854
(Month) (Day) (Year)

7-AGE, 65 yrs. 8 mos. 19 ds.
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Wood Finisher
(b) General nature of industry, business, or establishment in which employed (or employer), 186

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, Lazarus Barton

11-BIRTHPLACE OF FATHER, (State or Country), Balt. Md.

12-MAIDEN NAME OF MOTHER, Hannah German

13-BIRTHPLACE OF MOTHER, (State or Country), Balt. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary J. Barton

(Address) 106 S. Stricker St.

15-

JUN 24 1920

ROBERT B. BLAUGHTER

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 22, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1919, to June 22 1920, that I saw him alive on June 22 1920, and that death occurred, on the date stated above, at 5:30 P.M.
The CAUSE OF DEATH* was as follows:

.....
.....
.....

(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Intestinal Nephritis
(Duration) yrs. mos. ds.
(Signed) Walter A. Cox M. D.
6-23, 1920 (Address) 527 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Audon Park

DATE OF BURIAL, June 25 1920

20-UNDERTAKER, John O. Mitchell

ADDRESS, 1201 W. Fayette St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44239

D44239

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2400 E. Lafayette Ave. ST.; 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME W. Gora Kettlewell

(a) RESIDENCE. No. 2400 E. Lafayette Ave. ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of Charles Kettlewell (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22, 1856

7 AGE 64 Years 0 Months 0 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER ----- Norris

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Wilson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) Maryland

14 Informant Walter Kettlewell (Address) 2400 E. Lafayette Avenue

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1918, to June 22, 1920, that I last saw her alive on June 21, 1920, and that death occurred, on the date stated above, at 5:35 p. m. The CAUSE OF DEATH* was as follows:

Chronic Brights Disease

(duration) 2 or more yrs. mos. ds.

CONTRIBUTORY Dilatation of Heart (Secondary) (duration) 1 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? - Date of

Was there an autopsy? -

What test confirmed diagnosis?

(Signed) W. C. Sandrock, M. D.

23.6 1920 (Address) 1242 N. Bayway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL

6/25 1920

20 UNDERTAKER

ADDRESS

Henry W. Mears & Son 805 N. Calvert

PHYSICIAN should state EXACTLY how death occurred. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

JUN 24 1920

D44240

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

D44240

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3224 Barclay St. ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME X Baby Stewart(a) RESIDENCE. No. 3224 Barclay St. ST. 12 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 744 4 COLOR OR RACE aa 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of A

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, 3 hrs. or min.
27hs 1920 June 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work X(b) General nature of industry, business, or establishment in which employed (or employer) X(c) Name of employer X9 BIRTHPLACE (city or town) Maryland (Baltimore)
(State or country) Baltimore - Maryland10 NAME OF FATHER Arthur Stewart11 BIRTHPLACE OF FATHER (city or town) Boston Mass
(State or country) Maryland12 MAIDEN NAME OF MOTHER Anna F. Spence13 BIRTHPLACE OF MOTHER (city or town) Boston Mass
(State or country) Maryland

PARENTS

14 Informant (Address) Mother & Father
3224 Barclay St.

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23rd 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 22, 1920, to June 23, 1920,
that I last saw him alive on June 23, 1920,and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Premature Birth & physical condition of MotherCONTRIBUTORY (Secondary) 744 (duration) X yrs. 7 mos. — ds.
physical condition18 Where was disease contracted if not at place of death? XDid an operation precede death? X Date of XWas there an autopsy? noWhat test confirmed diagnosis? Inspection(Signed) Geo. S. Hall M. D.19 (Address) 424 E 23 St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

June 24 1920

20 UNDERTAKER

ADDRESS

Commissioner Health.

JUN 24 1920

Burial Clerk,

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every new entry should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44241

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44241

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Bush

(a) RESIDENCE. No. Unknown

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 49

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records (Address) New City Hospital

15 Filed Robert P. Harrison, 19 20

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1920

17 I HEREBY CERTIFY, That I attended deceased from October 10, 1917, to June 21, 1920, that I last saw him alive on June 21, 1920, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis & Hypertension;
Residual Hemiplegia (thrombosis);

(duration) 2 yrs. mos. ds.

CONTRIBUTORY Broncho-Pneumonia (Secondary) (duration) 6 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no special test

(Signed) J. P. Perrell M. D.

June 22 19 20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

UNIVERSITY OF MARYLAND June 24 1920

20 UNDERTAKER

ADDRESS

Commissioner Health.

JUN 24 1920

Burial Report (Clerk)

Physician should state EXACTLY. PHYSICIAN should state EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

141547
D44242

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D44242

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Johns Hopkins Hospital

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Dr. Wm. H. Coffman.

(a) RESIDENCE. NO.

Edmonson ave near Bolbing Road, Catonsville Md.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

3 yrs.

mos.

9 ds.

How long in U. S., if of foreign birth

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a ~~If married, with whom, as divorced~~

HUSBAND of

Mrs. Rosina Coffman

6 DATE OF BIRTH (month, day, and year)

May 26, 1875

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

55

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

J. C. Witt Coffman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Christine Herxlinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14 Informant (Address)

Mrs. Rosina B. Coffman
Edmonson ave near Bolbing Road, Catonsville

15

Robert P. Harrison,

Registrar

JUN 24 1920

Burial Permit clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 24 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 15, 1920, to June 24, 1920,

that I last saw him alive on June 24, 1920,

and that death occurred, on the date stated above, at 1:15 a. m.

The CAUSE OF DEATH* was as follows:

Atherosclerosis, myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocardial infarction

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) A. B. Bloomfield, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL

DATE OF BURIAL

New-Cathedral

June 26, 1920

20 UNDERTAKER

ADDRESS

George J. Smith, Fayette St.

D44243

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44243

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2133 Chelsea Ter 15* ST. WARD)

2-FULL NAME

(a) RESIDENCE. No. *2133 Chelsea Ter 15* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *Life time* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 22 1920*I HEREBY CERTIFY, that I attended deceased from *Jan 21*, 19*20*, that I last saw him alive on *June 22*, 19*20*, and that death occurred, on the date stated above, at *6 PM* m.

The CAUSE OF DEATH* was as follows:

Chronic Bulbar Paralysis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *D. E. Stank* M. D., 19 (Address) *1924 W. 1st Ave*

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

David Ridge Cemetery June 25 1920

20 UNDERTAKER

ADDRESS

George J. Smith 1000 W. 1st Ave

N. B.—WRITE PLAINLY, WITH CARE. INFORMATION should be stated EXACTLY, and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact classification of OCCUPATION is very important. See instructions on back of certificates.

JUN 24 1920

D44244

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44244

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 358 Rosebank ST.: 27 WARD)

2-FULL NAME

Isabell Heesh

(Residence in Baltimore: No. 358 Rosebank St. 27 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., 66 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

January 28, 1854

(Month)

(Day)

(Year)

7-AGE,

66 yrs. 4 mos. 26 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,

(State or Country),

Balto Md

10-NAME OF FATHER,

Chas F Fox

11-BIRTHPLACE OF FATHER

(State or Country),

Balto Md

12-MAIDEN NAME OF MOTHER

Ellen Crisp

13-BIRTHPLACE OF MOTHER

(State or Country),

Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John J. Heesh

(Address)

358 Rosebank Ave

15-

Robert P. Harrison,

191

Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 23, 1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and made an inquiry thereon and from the evidence obtained by said inquest and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Harrison D.

(Address) 168 L. R. Lane

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cemetery

DATE OF BURIAL,

June 25, 1920

20-UNDERTAKER

George Schilling & Son 126 E. Monument

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

JUN 24 1920

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN should state
cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44245

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6-091

D44245

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 So. Regester

ST.: 2nd. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard C. Bowen, Bowen,

(a) RESIDENCE. NO. 710 So. Regester
(Usual place of abode)

ST., 2nd. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. II mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male, 4 COLOR OR RACE white, 5 Single, Married, Widowed, or Divorced (write the word) Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4-1919.

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
II 20.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child, 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.,

10 NAME OF FATHER John Bowen, Bowen,

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.,

12 MAIDEN NAME OF MOTHER Molley Sietz,

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.,

14 Informant John Bowen, (Father)
(Address) 710 So. Regester Street

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1920

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1920, to June 24, 1920, that I last saw him alive on June 24, 1920, and that death occurred, on the date stated above, at 11.45 A. m. The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted Ridgely Md. if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene P. Perkowski, M. D. June 24, 1920 2314 E. Paul St. (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Stanislaus.

June 26 1920

20 UNDERTAKER

M. J. Sadowski.

405 S. Ann

JUN 24 1920

Burial Permit Clerk.

D44246

HEALTH DEPARTMENT—CITY OF BALTIMORE D44246

CERTIFICATE OF DEATH.

REGISTERED NO. 28✓

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 8 Spring ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Berne Pinion

(a) RESIDENCE. NO. 510 5. Spring

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 2 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1890

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 30

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address) George J. Ruth 1735 Haverford Ave

Robert P. Harrison,

Registrar

Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-23 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to June 23, 1920, that I last saw him alive on June 23, 1920, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Harrison, M. D.

14, 1920 Address 165 N. 1st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Evergreen Cemetery June 25 1920

20 UNDERTAKER

George J. Ruth 1735 Haverford Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A DEED IN BALTIMORE. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

JUN 24 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44247

CERTIFICATE OF DEATH.

D44247

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

328 E Federal

ST. 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Richard S. Hardy

(Residence in Baltimore: No.

328 E Federal

St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH

May 23, 1920
(Month) (Day) (Year)

7-AGE

1 yrs. 1 mos. 1 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

William E Hardy

11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Mary Keilly

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Keilly

(Address)

328 E Federal St.

15-

FILED

JUN 25 1920

ROBERT E. CLAUSER

Baltimore City Health Department

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

6 24, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

6/22 1920, to 6/24 1920,

that I saw him alive on 6/23 1920,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Gastroenteritis

(Duration) yrs. mos. ds. 3

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. Bernard Weiss M. D.

6/24, 1920 (Address) 914 E. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Catholic Cemetery June 25, 1920

20-UNDERTAKER

ADDRESS

Robt J Turner 1442 Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D44248

1-PLACE OF DEATH

REGISTERED NO.

D44248

CITY OF BALTIMORE: (No. 128. S High St ST. 3 WARD)

2-FULL NAME

Lillian Leper

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

128. S High St ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Dec. 18 / 1917

7 AGE

Years

Months

Days

LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

Maryland

10 NAME OF FATHER

Tony Leper

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Staten

12 MAIDEN NAME OF MOTHER

Anna Knappek

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

Maryland

14

Informant (Address)

Tony Leper

128. S High St

15

JUN 25 1920

ROBERT A. LEADZEE

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 23 1920

17

I HEREBY CERTIFY, That I attended deceased from June 19, 1920, to June 23, 1920, that I last saw her alive on June 23, 1920, and that death occurred, on the date stated above, at 2:30 P. M. The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 28 Date of

Was there an autopsy? 22

What test confirmed diagnosis?

(Signed) J. J. Ventura, M. D.

(Address) 1600 Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Vincent Cemetery

June 25 1920

20 UNDERTAKER

ADDRESS

M. J. Leper & Son 3304 Bay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44249

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *912* *Calhoun* ST.: *16* WARD)2-FULL NAME *Alice Campher*(a) RESIDENCE. No. *912* *Calhoun* ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*William E. Campher*6 DATE OF BIRTH (month, day, and year) *DEC 19th 75*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

44 *6* *3*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Wife & Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

Cooking - Washing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Joseph Campher

11 BIRTHPLACE OF FATHER (city or town) (State or country)

MD

12 MAIDEN NAME OF MOTHER

Sallie E. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MD

14

Informant (Address)

*Lottie E. Carter**Campher, N. J.*

15

Filed

*JUN 25 1920**ROBERT F. ERAUTER*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Jun 22 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*March 9, 1920, to June 22, 1920.*that I last saw her alive on *June 21, 1920.*

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation.(duration) yrs. *3* mos. ds.

CONTRIBUTORY (Secondary)

Minopams.(duration) yrs. *6* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical Examination*(Signed) *William H. Wright*, M. D.*24, 1920* (Address) *1209 Pressman*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*McArthur Ave**JUN 25 1920*

20 UNDERTAKER

ADDRESS

*Wm. H. Chase & Son**1400 Mosher*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PUBLIC DOCUMENT. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Dks.

D44250

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44250

6 - CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 Federal ST.: 12 WARD)

2-FULL NAME Sarah C. Crane

(a) RESIDENCE. No. 424 Federal ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 9 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 14-37

7 AGE Years 82 Months 9 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Rev Savage L. Hammond

11 BIRTHPLACE OF FATHER (city or town) MD (State or country)

12 MAIDEN NAME OF MOTHER Hannah Price

13 BIRTHPLACE OF MOTHER (city or town) MD (State or country)

14 Informant Hannah E. Perry (Address) 426 Federal

15 JUN 25 1920 ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14 1920 to June 23 1920 that I last saw her alive on Jan 22 1920 and that death occurred, on the date stated above, at 6:30 A.M. The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY Uræmia (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. V. Fitzgerald, M. D.

19 (Address) 1118 E. Mt. Vernon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Laurel Park June 26 1920

20 UNDERTAKER ADDRESS

Sam. W. Chase & Co. 1400 N. Charles

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D44251

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40

D44251

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 Compton ST. 24 WARD)

2-FULL NAME

Charles L Miller

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 900 Compton ST. 24 WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 4 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Mary Miller (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 7 1861

7 AGE Years 59 Months 4 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) md

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) md (State or country)

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) md (State or country)

14 Informant Mary Miller (Address) 900 Compton st

15 JUN 25 1920 ROBERT E FEATTEE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 19 20

17 I HEREBY CERTIFY, that I attended deceased from March 10 19 20, to June 23 19 20, that I last saw him alive on June 23 19 20, and that death occurred, on the date stated above, at 8 30 P m. The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Stomach analysis

(Signed) James H. O'Brien, M. D.

6/24/1920 (Address) 107 E West St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Cross A.C. Co Md JUN 26 1920

20 UNDERTAKER ADDRESS

John F Deming 715 Light

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D44252

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

D44252

PLACE OF DEATH

CITY OF BALTIMORE (No. 3137 Eastern Ave ST. 1 WARD)

2-FULL NAME Joseph Martin Esch

(Residence in Baltimore) No. 3137 Eastern Ave Sr. 64 yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Widower

6-DATE OF BIRTH Oct 23, 1860 (Month) (Day) (Year)

7-AGE 60 6 22 (yrs. mos. ds.) If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Retired (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Kenton Ky

10-NAME OF FATHER Henry Esch

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Veronica Huber

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Melton L Esch

(Address) 3137 Eastern Ave

15

JUN 25 1920

ROBERT H. KAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH June 23, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8 June, 1920, to 23 June 1920 that I saw him alive on 22 June, 1920, and that death occurred, on the date stated above, at 11:15 P. M. The CAUSE OF DEATH* was as follows:

Sanpurs of the lungs

Contributory (SECONDARY) Branchectasis (Duration) yrs. mos. 14 ds.

(Signed) Dr. Mohr M. D. (Address) 301 S. Ellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted? If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Oak Lawn Cem. June 25, 1920

20-ADDRESS Dr. Sander 1710 Reed

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44253

CERTIFICATE OF DEATH.

104 D44253

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Balt. Gen. Hosp. 22* ST. *22* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Dorothy Emsley

(a) RESIDENCE. No.

525 S Sharp St

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

6 mos. *6*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 5 - 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

6 mos -

-

6 days

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, City, Md.

10 NAME OF FATHER

George E. Emsley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Anna Tanner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

14

Informant (Address)

Hospital Record

15

JUN 25 1920

ROBERT E. KRAUTER Registrar

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 24 1920

17

I HEREBY CERTIFY, That I attended deceased from

6 - 24 1920 to *6 - 24 1920*

that I last saw her alive on *6 - 24 1920*

and that death occurred, on the date stated above, at *6:30 p.m.*

The CAUSE OF DEATH* was as follows:

(Marasmus.)
Cholera Infantum

(duration)

yrs.

mos.

14 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

8 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

R. R. Reynolds

M. D.

, 19 (Address)

1213 Higher St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill

6-25 1920

20 UNDERTAKER

ADDRESS

Ex B Harle

115 E West St

ORE ✓ D44255
120
REGISTERED NO

D44255

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(b) RESIDENCE. NO

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. 1 mos. ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27/1924

17 I HEREBY CERTIFY, That I attended deceased from June 7th, 1920, to June 22nd, 1920, that I last saw him alive on June 22nd, 1920.

and that death occurred, on the date stated above, at 4133 P m

The CAUSE OF DEATH* was as follows:

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

CONTRIBUTORY *for equal deposits*
(Secondary) *unknown*

18 Where was disease contracted
if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?.....

What test confirmed diagnosis? *Chemical*

(Signed) Wm. J. Sharkey M. D.
6/23/19 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL

29 UNDERTAKER	ADDRESS
---------------	---------

Mrs Scott Hooper 406 Conway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D44256

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 151 D44256
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 104 Monastery Ave ST. 20 WARD)

2-FULL NAME Isabelle Heed

(a) RESIDENCE. NO. 104 Monastery Ave ST. 20 WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5th 1920

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Frank Heed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Emma Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Frank Heed (Address) 104 Monastery Ave

15 Filed JUN 25 1920 ROBERT A. KAUTER Registrar Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20th 1920

17 I HEREBY CERTIFY, That I attended deceased from June 5th, 1920, to June 20th, 1920, that I last saw her alive on June 22nd, 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. J. Temple M. D.

, 19 (Address) 517 Scott St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park

June 25, 1920

20 UNDERTAKER

ADDRESS

C. H. Gill

3109
Fredk. Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44257

CERTIFICATE OF DEATH.

40

D44257

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Motherhouse of Notre Dame* ST.; *10* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Sister Mary Annella Boersing*(Residence in Baltimore: No. *Ashland Avenue & Argonith* St.; *30* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, *Single*
 MARRIED,
 WIDOWED,
 OR DIVORCED,
 (Write the word.)

6-DATE OF BIRTH, *July 16, 1841*
 (Month) (Day) (Year)

7-AGE, *48* yrs. *11* mos. ds. If LESS than 1 day,
 hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work *Headbook*
 (b) General nature of industry, business, or establishment in which employed (or employer) *Educational*

9-BIRTHPLACE, (State or Country), *Petersthal, Bavaria*

10-NAME OF FATHER, *Gabriel Boersing*

11-BIRTHPLACE OF FATHER (State or Country), *Bavaria*

12-MAIDEN NAME OF MOTHER *Christina Huber*

13-BIRTHPLACE OF MOTHER (State or Country), *Bavaria*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mother M. Anne*(Address) *Argonith Str. Baltimore*15- *JUN 25 1920* *ROBERT A. KRAUTER*16- *101* *BURIAL PLACE*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 24, 1920*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Oct 1910*, to *June 24, 1920*,
 that I saw her alive on *June 23, 1920*,
 and that death occurred, on the date stated above, at *4.4* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach
 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *J. J. Kelly* M. D.
June 24, 1920 (Address) *110 E. North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *25* yrs. mos. ds. In the *25* yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Milwaukee Wis.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Notch Cliff Rd *June 25, 1920*

20-UNDERTAKER ADDRESS

Frank A. Tink *915 N. Gay St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and other CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44258

CERTIFICATE OF DEATH.

151 D44258

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1536 Abbottston ST. 9 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Dey

(a) RESIDENCE. No. 1536 Abbottston ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 1/2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23 1920

7 AGE Years Months Days If LESS than 1 day, 12 hrs. or min. 1 1/2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

10 NAME OF FATHER Melvin A. Dey

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. McBrinnidy

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mr. Melvin A. Dey (Address) 1536 Abbottston St.

15 Filed JUN 25 1920 ROBERT I. ELAETER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1920

17 I HEREBY CERTIFY, That I attended deceased from June 23 1920, to June 24 1920, that I last saw him alive on June 24 1920, and that death occurred, on the date stated above, at 9 P. M. The CAUSE OF DEATH was as follows:

Structure birth of the lungs. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. D. Selinger, M. D.

19 (Address) 1501 E. Bay View

State in brief, Cause of death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cemetery

June 25 1920

20 UNDERTAKER

ADDRESS

Henry Horch Sen

1301 E. Bay View

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 27 WARD)

REGISTERED NO. D44259

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Glieve

(a) RESIDENCE. No. 728 E. Arlington Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

May 1920

mos.

ds.

How long in U. S., if of foreign birth

May 1920

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
60

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

10 NAME OF FATHER Charlie Glieve

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Hospital Records
(Address) New City Hospital

15 File JUN 25 1920 ROBERT B. KRAUTER
Registrar
Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1920 to June 24, 1920, that I last saw him alive on June 23, 1920, and that death occurred, on the date stated above, at 3:50 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Far advanced)

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted City
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Sputum
(Signed) J. F. Pessel M. D.

(Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmanuel Cemetery (Dorchester) DATE OF BURIAL June 26 1920

20 UNDERTAKER Henry Horch Lw ADDRESS 1301 E. Eager

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44260

CERTIFICATE OF DEATH.

79 D44260

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 W Pratt St. 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1524 W Pratt St. 2 yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

M.

4-COLOR OR RACE,

W.

5-SINGLE,
MARRIED,
WIDOWED,
DIVORCED
(Write the word.)

6-DATE OF BIRTH,

Feb.

3

1918

(Month)

(Day)

(Year)

7-AGE,

2

4

20

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

9-BIRTHPLACE,
(State or Country),

City

10-NAME OF
FATHER,

Paul J. Genger

11-BIRTHPLACE
OF FATHER
(State or Country),

Baltimore

12-MAIDEN NAME
OF MOTHER

Kate Selwallby

13-BIRTHPLACE
OF MOTHER
(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul J. Genger

(Address) 1524 W Pratt St.

15-

JUN 25 1920

ROBERT B. KRAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June

23

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 12 1920, to June 23 1920,

that I saw him alive on June 22 1920,

and that death occurred, on the date stated above, at 12:29 am.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

.....

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY..... Cardiac asthma

..... (Duration)..... yrs..... mos..... ds.

(Signed) Edward S. Neveling M. D.

624, 1912 (Address) 74 W Fulton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Baltimore

DATE OF BURIAL,

6/25, 1920

20-UNDERTAKER

J. A. Moran

ADDRESS

3000 E Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44261

CERTIFICATE OF DEATH.

D44261

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 373 H. Lemmon WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 373 H. Remond St.: _____ yrs. _____ mos. _____ da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE

6-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

10-DATE OF DEATH.

6-24-1920
(Month) (Day) (Year)

•-DATE OF BIRTH.

Apr. 10, 1919
(Month) (Day) (Year)

7-AGE

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country).

10-NAME OF
FATHER,

11-BIRTHPLACE
OF FATHER
(State or Country)

12-MAIDEN NAME
OF MOTHER

13-BIRTHPLACE
OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address) 070 W. Broadway

18-

ROBERT F. CRAUTER

Filed JUN 25 1920 191...
Registrar.

MEDICAL CERTIFICATE OF DEATH.

17- I HEREBY CERTIFY, That I attended deceased from
6-10 1920, to 6-24 1920.
that I saw her alive on 6-24- 1920.
and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

..... (Duration) yrs. mos. ds.
CONTRIBUTORY..... *Acute Solar pneumonia*
(Secondary) *8/*

(Duration) yrs. mos. ds.
(Signed) S. Smarck M. D.
(-25-, 1910) (Address) 1604 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.
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Where was disease contracted,
if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.

DATE OF BURIAL,

[illegible]

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHIL-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION
important. See instructions on back of certificate.

D44262

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D44262

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 143 N. Streeper ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 143 N. Streeper ST. 6 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

N.

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balti. Md.

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Maie Steigermald

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balti. Md.

14

Informant (Address)

Maie Steigermald
143 N. Streeper St

JUN 25 1920

ROBERT F. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 24 19 20

17

I HEREBY CERTIFY, That I attended deceased from June 24, 19 20, to June 24, 19 20.that I last saw him alive on June 24, 19 20.and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Congenital Heart DiseaseCONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Prolonged

18 Where was disease contracted if not at place of death?

Did an operation precede death? N Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. H. Meyer, Jr. M. D.(Address) 1630 E. Balt. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Patricks Church

20 UNDERTAKER

J. A. Moran

DATE OF BURIAL

6/25/1920

ADDRESS

3000 E. Balt. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PRELIMINARY REPORT. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44263

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44263

1-PLACE OF DEATH *Bayview Hospital* 170
CITY OF BALTIMORE: (Name) *Joseph Lynch* ST.: *10* WARD) *10*
2-FULL NAME *Joseph Lynch*
(a) RESIDENCE. NO. *836 Hartford Ave.* WARD. *10*
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced *Widow*
5a If married, widowed, or divorced HUSBAND of *Unknown* (or) WIFE of *Unknown*
6 DATE OF BIRTH (month, day, and year) *1845*
7 AGE Years Months Days If LESS than 1 day, hrs. or min. *75*
8 OCCUPATION OF DECEASED *Nurse*
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) *Ireland* (State or country)
10 NAME OF FATHER *John Mc Kuer*
11 BIRTHPLACE OF FATHER (city or town) *Ireland* (State or country)
12 MAIDEN NAME OF MOTHER *Margaret Mullin*
13 BIRTHPLACE OF MOTHER (city or town) *Ireland* (State or country)

14 Informant *Bayview Hospital* (Address) *Baltimore, Md.*
15 Filed *JUN 25 1920* *ROBERT A. LEADY* Registrar
Burial Permit *01871*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 24, 1920*
17 I HEREBY CERTIFY, that I attended deceased from *Oct 3, 1912* to *June 24, 1920*
that I last saw *her* alive on *June 24, 1920*
and that death occurred, on the date stated above, at *10:40 A.M.*
The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

CONTRIBUTORY *Arterio Sclerotic Changes* (duration) yrs. mos. ds.
Secondary (duration) yrs. mos. ds.

18 Where was disease contracted *Unknown* if not at place of death?
Did an operation precede death? *No* Date of *No*
Was there an autopsy? *No*
What test confirmed diagnosis? *Phys. 31 am.*
(Signed) *H. G. Smith* M. D.
(Address) *Bayview Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Cathedral* DATE OF BURIAL *June 26 1920*
20 UNDERTAKER *H. C. Wiedefeld* ADDRESS *914 Greenmount*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44264

CERTIFICATE OF DEATH.

28 D44264

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 5 WARD)2-FULL NAME Joseph Denz

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 332 N. Gay St.ST. 5 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night watchman(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) Philadelphia
(State or country) Pennsylvania10 NAME OF FATHER Joseph Denz11 BIRTHPLACE OF FATHER (city or town) France
(State or country)12 MAIDEN NAME OF MOTHER Louise ?13 BIRTHPLACE OF MOTHER (city or town) France
(State or country)14 Informant Hospital Records
(Address) M.T.H.15 Filed JUN 25 1920 ROBERT A. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24th 1920

17 I HEREBY CERTIFY, That I attended deceased from
May 29, 1920, to June 24, 1920,
that I last saw him alive on June 23, 1920,
and that death occurred, on the date stated above, at 7.45 a.m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 5 yrs. 7 mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis T.B. in sputum, X-ray.(Signed) Crawford A. Hart M. D.6-24-20 Addressed Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. CarmelJune 25 1920

20 UNDERTAKER

ADDRESS

Philip Herwig2016
Oleum

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PUBLIC RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D44265

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44265

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

73 yrs. 7 mos. 26 ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

m

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

James S. Fenhagen

6 DATE OF BIRTH (month, day, and year)

Oct. 28, 1846

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

73

7

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Vice President of 080

(b) General nature of industry, business, or establishment in which employed (or employer)

Baltimore Trust Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

James C. Fenhagen

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Maryland

12 MAIDEN NAME OF MOTHER

Mary A. Denny

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant

Mrs. William S. Brownlee

(Address)

205 Roland Ave

15

Filed

Robert P. Harrison,

Registrar

ST.: 37th WARD)

ST.: 27th WARD.

(If nonresident give city or town and State)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 24, 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 30, 1920, to June 24, 1920,

that I last saw him alive on June 24, 1920,

and that death occurred, on the date stated above, at 8-45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Chronic Bright's Disease

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) M. Gibson Forten, M. D.

, 19 (Address) Roland Park Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Greenmount Cem

DATE OF BURIAL

6-26 1920

20 UNDERTAKER

Henry W. Jenkins Son Co McCallister

N. B.—WRITE PLAINLY, WITH UNFADING INK. INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIAN'S STATEMENT OF CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

JUN 25 1920

Burial Permit Clerk.

D44266

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44266

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C

2-FULL NAME

Clark Bryan

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

St. Elizabeth's Home

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *Black* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

....., 1.....
(Month) (Day) (Year)

7-AGE,

about

If LESS than 1 day,

yrs. 4 mos. ds.

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country),

admitted to St. Elizabeth's May 21/20
sent by Judge P. Scott O'Neil
Jurassic Co. Balt. Co.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

Pinky Bryan

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Robert P. Harrison,

JOHNS HOPKINS HOSPITAL

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 23, 191²⁰
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 9 191²⁰, to *June 23* 191²⁰,

that I saw h *alive* on *June 23* 191²⁰,

and that death occurred, on the date stated above, at *9 P.* m.

The CAUSE OF DEATH* was as follows:

Internal Decomposition

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *Frank J. Ayer* M. D.

June 24, 191²⁰ (Address) *2605 E. Monument St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

JUN 25 1919

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 25 1920

17312

D44267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D44267

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital)

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Petroch(a) RESIDENCE. NO. Unknown

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 18 52

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
68				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER Unknown June 23, 1920 (Address) New City Hospital.13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)14 Informant Hospital Records
(Address) New City Hospital.15 Robert P. Harrison,

Registrar

Burial Permit Clerk

20 UNDERTAKER

Commissioner, Health.

Wm. W. WOODALL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1920

17

I HEREBY CERTIFY, That I attended deceased from
June 6, 19 20, to June 23, 19 20.that I last saw him alive on June 22, 19 20.and that death occurred, on the date stated above, at 7:30 A.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis;
Senile Dementiaunknown (duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)Bronchitis-Pneumonia
(duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? no special test(Signed) J. P. Perrot, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND.

ADDRESS

JUN 25 1920

N. B.—WRITE PLAINLY, WITH CARE. INFORMATION should be stated EXACTLY. PHYSICIAN should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D44268

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44268

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST.: *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Bennett

(a) RESIDENCE. NO.

520 Glenwood Ave

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Black* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *✓*

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *0 0 6*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*(b) General nature of industry, business, or establishment in which employed (or employer) *None*(c) Name of employer *None*9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *James Hill*11 BIRTHPLACE OF FATHER (city or town) (State or country) *MD*12 MAIDEN NAME OF MOTHER *Lela Bennett*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *MD*

PARENTS

14 Informant (Address) *R. P. Harrison, Johns Hopkins Hospital*15 Filed *Robert P. Harrison,* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 21 1920*17 I HEREBY CERTIFY, That I attended deceased from *June 26*, 19*20*, to *June 21*, 19*20*.that I last saw him alive on *June 21*, 19*20*.and that death occurred, on the date stated above, at *3 P. m.*

The CAUSE OF DEATH* was as follows:

Septicemia (Streptococcus)

CONTRIBUTORY

(Secondary)

18 Where was disease contracted if not at place of death? *✓*Did an operation precede death? Date of *yes*Was there an autopsy? *yes*

What test confirmed diagnosis?

(Signed)

4/23 1920 Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS 1919

JUN 2 1919

N. B.—WRITE PLAINLY, WITH UNFADING INK. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

JUN 25 1920

Burial Clerk

D44269

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44269

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hospital* ST. *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Miller

(a) RESIDENCE. NO.

*Father's address**253 S. Danvers* ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Infant*

6 DATE OF BIRTH (month, day, and year)

6/21/20

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

(c) Name of employer

*none*9 BIRTHPLACE (city or town)
(State or country)*Med. General Hosp.*

10 NAME OF FATHER

*Joe Miller*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Baltimore
Maryland*

12 MAIDEN NAME OF MOTHER

*Mary Casper*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Baltimore
Maryland*

14

Informant
(Address)*Mrs. Mary Miller (mother)
253 S. Danvers St.*

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 23 1920

17

I HEREBY CERTIFY, That I attended deceased from
June 21, 19*20*, to *June 23*, 19*20*,
that I last saw her alive on *June 23*, 19*20*,and that death occurred, on the date stated above, at *9 a.* m.

The CAUSE OF DEATH* was as follows:

Prematurity - Tillman of gestation.(duration) yrs. mos. *2* ds.CONTRIBUTORY
(Secondary)*Eclampsia of mother*(duration) yrs. mos. *2* ds.18 Where was disease contracted
if not at place of death?*Med. Gen. Hosp.*

Did an operation precede death?

Yes Date of *June 21*

Was there an autopsy?

to

What test confirmed diagnosis?

History and Phys. Exam.

(Signed)

William B. Bacon

M. D.

6/23/20 (Address)

Med. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*HOPKINS HOSPITAL**JUN 24 1920*

20 UNDERTAKER

Commissioner Health

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIAN'S STATEMENT OF OCCUPATION IS VERY IMPORTANT. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44270

CERTIFICATE OF DEATH.

151 D44270

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *10 E Gettins* ST.: *23* WARD)2-FULL NAME *Arthur Henry Johnson*(a) RESIDENCE. NO. *10 E Gettins* ST.: _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos. *16*

ds.

How long in U. S., if of foreign birth?

yrs.

mos. *16*

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 8/20*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto Md*10 NAME OF FATHER *Arthur Johnson*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto*12 MAIDEN NAME OF MOTHER *Elizabeth Frank*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto*

14

Informant (Address)

*Arthur Johnson
10 E Gettins St*

15

Filed

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 24 1920*

17

I HEREBY CERTIFY, That I attended deceased from

June 8, 19*20*, to *June 24*, 19*20*.that I last saw him alive on *June 24*, 19*20*.and that death occurred, on the date stated above, at *10 40* m.

The CAUSE OF DEATH* was as follows:

*Premature birth -
8 mos gestation*

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Abuse of life

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *physical*(Signed) *Wm. Stigler* M. D.

4/25, 1920 (Address)

1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cedar Hill Cem**June 26 1920*

20 UNDERTAKER

ADDRESS

*Joseph B. Cook**1003 N. Balto
Spur*

N. B.—WRITE PLAINLY, WITH CARE. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

JUN 25 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44271

D44271

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Prestman & Payson* ST.: *16* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *Prestman & Payson* ST. *16* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *76* yrs. mos. ds. How long in U. S., if of foreign birth? *76* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
<i>Female</i>	<i>White</i>	<i>Married</i>

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Harry A. Turner.*6 DATE OF BIRTH (month, day, and year) *Jan. 12 - 1890*

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<i>50</i>	<i>5</i>	<i>12</i>	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant *Harry A. Turner.*
(Address) *Prestman & Payson St.*

15

Filed *Robert P. Harrison,* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 24 1920*17 I HEREBY CERTIFY, That I attended deceased from *June 23* *1920*, to *June 24* *1920*, that I last saw her alive on *June 23* *1920*, and that death occurred, on the date stated above, at *8 A.* m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus
*(Acidosis)*CONTRIBUTORY (Secondary) *Abac* (duration) *1* yrs. mos. ds. *Chronic Interstitial Nephritis*
Abac (duration) *9* yrs. mos. ds.18 Where was disease contracted *At home* if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Chemical & Microscopic*(Signed) *O. H. Duval* M. D.19 (Address) *1817 N. Fulton St.*

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Ch.**June 26 1920*

20 UNDERTAKER

ADDRESS

*Lilly and Zeller**403 S. Wof*

N. B.—WRITE PLAINLY, WITH CARE. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

JUN 25 1920

Burial Permit Clerk

D44272

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *919 S. First*)ST.; *26* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Catherine Leitner*(Residence in Baltimore: No. *919 S. First*)St.; *29* yrs., *11* mos. *25* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

June 29, 1890
(Month) (Day) (Year)

7-AGE,

29 yrs., 11 mos., 25 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....*Housework*
(b) General nature of industry, business, or establishment in which employed (or employer).....*at home*

9-BIRTHPLACE, (State or Country),

Baltimore Co., Md.

10-NAME OF FATHER,

Daniel A. Leitner

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore Co., Md.

12-MAIDEN NAME OF MOTHER

Mary Barbara Heuser

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....*Mary Barbara Leitner*(Address).....*919 S. First St.*

15-

Filed.....

Robert P. Harrison

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 24, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *April 15, 1920*, to *June 24, 1920*, that I saw her alive on *June 24, 1920*, and that death occurred, on the date stated above, at *1 p. m.* The CAUSE OF DEATH* was as follows:*Chronic Bronchitis*
(Not tuberculous)
(Duration).....*3* yrs., *9* mos., *9* ds.CONTRIBUTORY.....*Asklepiasis*
(Secondary)(Duration).....*7* yrs., *7* mos., *7* ds.
(Signed).....*Geo. F. Schuchler* M. D.
June 24, 1920 (Address).....*Sub. St. 3rd Fl.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Josephs Cem.

DATE OF BURIAL,

June 28, 1920

20-UNDERTAKER

Lily and Zulu

ADDRESS

403 S. Wolfe

N.B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 25 1920

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44273

D44273

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C

2-FULL NAME

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

St. 45 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

JUN 25 1920

Robert P. Harrison

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on June 20 1920,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed) F. A. Warner M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 yrs. 4 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

D44274
40

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44274

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *11* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs. Rosa Bloomfield

(a) RESIDENCE. NO.

561 Park Ave.

ST.

WARD.

Chicago, Ill.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

40 yrs. *unknown* mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

2.

6 DATE OF BIRTH (month, day, and year)

Dec 12 1863

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*56**6**27*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Austria

10 NAME OF FATHER

Isaac Zisker

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Austria

12 MAIDEN NAME OF MOTHER

Anna Kanner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Austria

14

Informant (Address)

J. H. H. Records

15

Filed

Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 25 1920

17

I HEREBY CERTIFY. That I attended deceased from

*May 12 1920, to June 25 1920,*that I last saw him alive on *June 25 1920,*and that death occurred, on the date stated above, at *11 P. m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach (operative findings - inoperable)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *yes* Date ofWas there an autopsy? *yes*

What test confirmed diagnosis?

(Signed)

Adrian S. Taylor

M. D.

, 19

(Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Chicago Ill**June 26 1920*

20 UNDERTAKER

ADDRESS

W. Jenkins & Son Co

N. B.—WRITE FULL NAME, ADDRESS, AND AGE OF DECEASED, AND STATEMENT OF OCCUPATION, on back of certificate. See instructions on back of certificates.

JUN 25 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44275

CERTIFICATE OF DEATH.

D44275

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

ST.

WARD.

Length of residence in city or town where death occurred

53 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

53 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Aloisia Guth

6 DATE OF BIRTH (month, day, and year)

March 19-1838

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

82

3

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

631

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Joseph Guth

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mrs. Schmitz
42 S. Pulaski

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 23 1920

17

I HEREBY CERTIFY, that I attended deceased from

June 22, 1920, to June 23, 1920,

that I last saw him alive on June 22, 1920,

and that death occurred, on the date stated above, at 4:15 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Hemiplegia)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Arterio Sclerosis

(duration) yrs. mos. ds.

Unknown

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) Mrs. Schmitz, M. D.

(Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

June 26 1920

20 UNDERTAKER

ADDRESS

Geo. R. Schmitz 1307 21st Ave

D44276

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44276

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (Municipal Tuberculosis Hospital 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walker Levering

(a) RESIDENCE. No. 3801 Frederick Ave.

ST. 20 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs.

mos.

ds.

How long in U. S., if of foreign birth? 28 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Grave digger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Jessie Levering

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Wolfe

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland14 Informant Hospital Records
(Address) M. T. H.

15 Filed Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 1920

17

I HEREBY CERTIFY, That I attended deceased from
March 11, 1920, to June 25, 1920,

that I last saw him alive on June 24, 1920,

and that death occurred, on the date stated above, at 12.20 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 11 yrs. 11 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Crawford A. Hart, M. D.

6-25-20, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park

June 28, 1920

20 UNDERTAKER

ADDRESS

George L. Schmatz, 3101 Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44277

CERTIFICATE OF DEATH.

D44277

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Kreager(a) RESIDENCE. No. 1620 Thames St.

(Usual place of abode)

ST. 2 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofMichael Kreager6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Minnesota10 NAME OF FATHER Wm. L. Riley11 BIRTHPLACE OF FATHER (city or town) St. Louis
(State or country) Missouri12 MAIDEN NAME OF MOTHER Annetta Kenny13 BIRTHPLACE OF MOTHER (city or town) St. Paul.
(State or country) Minnesota14 Informant Hospital Records(Address) M.T.H.15 Filed Robert P. Harrison,

19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 192017 I HEREBY CERTIFY, That I attended deceased from
April 16, 1920, to June 24, 1920.that I last saw h. or alive on June 24, 1920.and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) yrs. 4 mos. ds.CONTRIBUTORY Tuberculous enteritis
(Secondary)(duration) yrs. 1 mos. 18 ds.18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum(Signed) Crawford C. Hart, M. D.
6-24-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Trinity Cemetery

20 UNDERTAKER

Wendell Huppel

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44278

CERTIFICATE OF DEATH.

6-091 D44278

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 E. Lombard ST.; 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Mancuso(Residence in Baltimore: No. 1020 E. Lombard St.; 1 yrs., 4 mos., 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

December 11, 1917
(Month) (Day) (Year)

7-AGE,

2 yrs., 6 mos., 14 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....None9-BIRTHPLACE,
(State or Country),Balto Ind

PARENTS.

10-NAME OF FATHER,

Alfonse Mancuso11-BIRTHPLACE OF FATHER
(State or Country),Italy

12-MAIDEN NAME OF MOTHER

Alicandra Martellucci13-BIRTHPLACE OF MOTHER
(State or Country),Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Stephan S. Suedolce

(Address).....

1020 E. Lombard

15-

Robert P. Harrison,

191.....

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 20, 1920, to June 25, 1920,that I saw her alive on June 20, 1920,and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

June 25, 20 (Address).....2314 E. Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Vincent's CemeteryJune 26, 1920

20-UNDERTAKER

ADDRESS

Handel & Pappas372 Camden

N. B.—Every item of information should be carefully supplied. Accuracy of statement of OCCUPATION is especially important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44279

CERTIFICATE OF DEATH.

D44279

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *941 Forest* ST.; *10* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John S. Boyle*(Residence in Baltimore: No. *941 Forest* St. *Life* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH,

..... *Unknown* 18*49*
(Month) (Day) (Year)

7-AGE,

71 yrs. mos. ds.If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Labor.*
(b) General nature of industry, business, or establishment in which employed (or employer) *040*

9-BIRTHPLACE, (State or Country),

*Balto.*10-NAME OF FATHER, *John Boyle*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER *Mary Kuffy*13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *James Harrison*(Address) *939 Forest St.*

15-

JUN 26 1920 Robert P. Harrison,
Filed 191.....

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

..... *June 23* 19*20*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 22* 19*20*, to *June 23* 19*20*, that I saw *him* alive on *June 23* 19*20*, and that death occurred, on the date stated above, at *3:30* a.m.

The CAUSE OF DEATH* was as follows:

Bronch. Pneumonia

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) *James M. Harrison* M. D.*June 25* 19*20* (Address) *2001 Chase St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the yrs. mos. ds. State

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral *June 24* 19*20*

20-UNDERTAKER

E. A. Wiedefeld *Summit*

N.B.—Every item of information should be carefully supplied. AGE must be in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D44280

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44280

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.

WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

8-LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF
FATHER,

11-BIRTHPLACE
OF FATHER
(State or Country),

12-MAIDEN NAME
OF MOTHER

13-BIRTHPLACE
OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

find that said deceased came to death
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Bulld wound in abdomen
Internal Hemorrhage

CONTRIBUTORY
(Secondary)

(Signed)

6-26, 1920 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-
SIENTS, OR RECENT RESIDENTS).

At place In the
of death.... yrs..... mos..... ds. State.... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence St. Michaels

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER ADDRESS

Joseph A. Farrell 2319 Division

44281
D44281

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).9-BIRTHPLACE,
(State or Country),

PARENTS.

10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country),12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed 1920 Robert P. Harrison,

191.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an...
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said...
(Inquest, au-topsy or inquiry... find that said deceased came to... death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. femur and shock.
caused by... falling on...
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) ... M. D.
(Coroner.)

Jan. 24, 1920. (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRAN-
SIENTS, OR RECENT RESIDENTS).At place ... In the
of death ... yrs. mos. ds. State ... yrs. mos. ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Burial Permit Clerk

44282

D44282

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. Baby Stawfield St.; 0 yrs., 0 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, Single
 MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, June 23, 1920
 (Month) (Day) (Year)

7-AGE, 0 yrs., 0 mos., 1 ds. If LESS than 1 day, 10 hrs. or min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work, None
 (b) General nature of industry, business, or establishment in which employed (or employer), None

9-BIRTHPLACE, (State or Country), Hebrew Hospital Balto.

10-NAME OF FATHER, John M. Stawfield

11-BIRTHPLACE OF FATHER (State or Country), Howard Co. Md.

12-MAIDEN NAME OF MOTHER, Anna Roop

13-BIRTHPLACE OF MOTHER (State or Country), Carroll Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Robert P. Harrison,

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 24, 1920.
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 23, 1920, to June 24, 1920, that I saw her alive on June 24, 1920, and that death occurred, on the date stated above, at 3 A. m. The CAUSE OF DEATH* was as follows:

Prematurity
10 hours
 (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
 (Secondary)

(Signed) Harry Baedemann M. D.
6/25, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Carnegie Hebrew Home 6-24, 1920

20-UNDERTAKER ADDRESS

N.B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Important. See instructions on back of certificate.

JUN 28 1920

44283
D44283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 38 W. Biddle

ST.: 11 WARD)

2-FULL NAME

Metilda G. Ober

(a) RESIDENCE, NO.

38 W. Biddle

(Usual place of abode)

ST.: 11 WARD.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

67 yrs. 5 mos. 6

ds.

How long in U. S., if of foreign birth?

Life

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 19th 1853

7 AGE

67

Years

Months

5

Days

6

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Home Lady

(b) General nature of industry,
business, or establishment in
which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

Gustavus Ober

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Montgomery Co. Md.

12 MAIDEN NAME OF MOTHER

Rebecca Keltwell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Perryman

14

Informant

(Address)

Rebecca Hickok

38 W. Biddle St

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

11

WARD)

ST.: 11 WARD.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 20th 1920

17

I HEREBY CERTIFY, That I attended deceased from
April 20th, 1920, to June 20th, 1920,
that I last saw her alive on June 24th, 1920,
and that death occurred, on the date stated above, at 7:45 A.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris in association with
failure of cardiac compensation
resulting from mitral insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY
(Secondary)

Mitral Insufficiency

(duration) 3 yrs. 1 mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. D. Dabney, M. D.

, 19 (Address) Puxton Md

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cem

6-27 1920

20 UNDERTAKER

ADDRESS

Henry E. Kinslow

Archard

JUN 26 1920

N. B.—WRITE FULL NAME OF DECEASED, AGE, SEX, OCCUPATION, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44284

D44284

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *936 Emsw*ST.: *10* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sam DeLuca(a) RESIDENCE, NO. *936 Emsw*

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *15* yrs.

mos.

ds. How long in U. S., if of foreign birth? *15* yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 25-1884*

7 AGE

Years

Months

Day

If LESS than 1 day, hrs. or min.

35-11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Barber*9 BIRTHPLACE (city or town) (State or country) *Italy*10 NAME OF FATHER *August DeLuca*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Italy*12 MAIDEN NAME OF MOTHER *Ann Marie DeLuca*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Italy*

PARENTS

14 Informant (Address) *Robert P. Harrison, Registrar*

15

Filed *Robert P. Harrison, Registrar*

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *6-25-1920*17 I HEREBY CERTIFY, That I attended deceased from *June 1st*, 19*19*, to *June 25th*, 19*20*. That I last saw him alive on *June 25*, 19*20*.and that death occurred, on the date stated above, at *6 PM* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *TB x Phys. exam*(Signed) *M. Chedoke* M. D.19 (Address) *7328 Madison av*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St Vincent 502 E Pratt

D44285

HEALTH DEPARTMENT--CITY OF BALTIMORE

D44285

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1920 McElderry*)ST.: *7* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1920 McElderry*)St.: *55* yrs., *10* mos., *17* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH, *April 6, 1843*
(Month) (Day) (Year)

7-AGE, *77 yrs. 2 mos. 17 ds.* If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Retired*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Germany*

PARENTS.

10-NAME OF FATHER, *Justus H. Tangebeck*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER, *unknown*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George H. Harrison*(Address) *1920 McElderry*

15-

Filed

Robert P. Harrison,

191

Registrar.

Burial Permit Cleared

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 24, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan. 3, 1904* to *June 24, 1920*, that I saw him alive on *June 24, 1920*, and that death occurred, on the date stated above, at *4:15 P.M.*

The CAUSE OF DEATH* was as follows:

Endocarditis(Duration) *10 yrs. 10 mos. 10 ds.*CONTRIBUTORY (Secondary) *Paralysis*(Duration) *16 yrs. 6 mos. 10 ds.*(Signed) *J. J. Harrison* M. D.*June 25, 1920* (Address) *1001 Wisconsin St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *10 yrs. 10 mos. 10 ds.* In the State *10 yrs. 10 mos. 10 ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *McBarnes*DATE OF BURIAL, *June 27, 1920*20-UNDERTAKER, *Philip Hernig*ADDRESS *3016**Quilans*

N.B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D. 44286 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Balto Gen. Hospital* WARD)

2-FULL NAME

Laurence Uttenreither(a) RESIDENCE, No. *South Balto Gen. Hospital* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. *45*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male.* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *single.*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of *Baluy.*

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

1 15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *md.*10 NAME OF FATHER *Fred Nestor*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *md.*12 MAIDEN NAME OF MOTHER *Helen Uttenreither*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *md.*14 Informant *Helen Uttenreither* (Address) *922 Bunsbury St. City*15 Filled *Robert J. Clark* Registrar

JUN 26 1920

Permit *Clark*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *6-24* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

May 10, 19 *20*, to *6-24*, 19 *20*.that I last saw him alive on *6-24*, 19 *20*.and that death occurred, on the date stated above, at *1-30 p.m.*

The CAUSE OF DEATH* was as follows:

1. Malnutrition(duration) yrs. *1* mos. ds.

CONTRIBUTORY (Secondary)

infection in cervical region (duration) yrs. mos. *7* ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *R. R. Reynolds* M. D., 19 (Address) *1213 Light St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*S HOPKINS HOSPITAL**JUN 25 1919*

20 UNDERTAKER

ADDRESS

Commissioner Health

tion should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D44287

HEALTH DEPARTMENT—CITY OF BALTIMORE D44287

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Md. General Hospital 11

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Geo. W. Elsner

(a) RESIDENCE. NO.

Bel Air Md.

ST.

WARD.

Bel Air Md

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

21

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorred (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

Unknown/868

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

about 52

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Self

9 BIRTHPLACE (city or town) (State or country)

Harford Co Md

10 NAME OF FATHER

John Elsner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Aldermany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Henry Taring Aberdeen

JUN 26 1920

Robert F. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 25 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 12 1920, to June 25, 1920,

that I last saw him alive on June 25, 1920,

and that death occurred, on the date stated above, at 5:40 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Bel Air Md.

Did an operation precede death? yes Date of May 21, 1920

Was there an autopsy? no

What test confirmed diagnosis? Pathological Examination

(Signed) H. S. Wright, M. D.

25, 1920 Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Aberdeen Md

June 26, 1920

20 UNDERTAKER

ADDRESS

Wm. T. Tucker 1000 North St

HEALTH DEPARTMENT—CITY OF BALTIMORE

2-44288

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 S. Mountford St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Anton Borrowski

(Residence in Baltimore: No. 735 S. Mountford St.; yrs. 3 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

June 9, 1920.
(Month) (Day) (Year)

7-AGE,

yrs. 3 mos. 16 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Joseph Borrowski

11-BIRTHPLACE OF FATHER (State or Country),

Poland

12-MAIDEN NAME OF MOTHER

Katherine Pawlak

13-BIRTHPLACE OF MOTHER (State or Country),

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ... Mr. R. Sadowski

(Address) ... 705 S. Ann St.

15-

Filed

JUN 26 1920

Robert P. Harrison,

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 25, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 24 1920, to June 24 1920, that I saw him alive on June 24 1920, and that death occurred, on the date stated above, at 10 a.m. The CAUSE OF DEATH* was as follows:

18- (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY ... (Secondary) ...

(Signed) ... M. D.
June 25, 1920. (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus.

DATE OF BURIAL,

6/26-1920.

20-UNDERTAKER

M. F. Sadowski, 705 S. Ann St.

N. B.—Every item of information should be carefully supplied in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

44289

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 44289

PLACE OF DEATH

CITY OF BALTIMORE (No. 1923 Brun St

St.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give the NAME instead of street and number and fill out No. 18.)

FULL NAME

Ella Johnson

(Residence in Baltimore: No. 1923 Brun St.

St.; yrs. 60 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

60 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Cook

(b) General nature of industry, business, or establishment in which employed (or employer).

Household

9-BIRTHPLACE, (State or Country),

Balto. Md.

10-NAME OF FATHER,

Dandridge Spindell

11-BIRTHPLACE OF FATHER, (State or Country),

South Virginia

12-MAIDEN NAME OF MOTHER,

Rachael Johnson

13-BIRTHPLACE OF MOTHER, (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Bella Ray

(Address)

910 Pear St.

15-

1920

26

Robert P. Harrison,

Burial Permitted Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 25, 1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

opsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Unknown (Duration) yrs. mos. ds.

(Signed) D. J. Hennessy, M. D. (Coroner.)

June 25, 1920 (Address) 2802 Edgemoor Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Cemetery

June 28, 1920

20-UNDERTAKER

ADDRESS

HEP & B Ry

102 E. Mulberry

D44290

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44290

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 Boyle St. ST.: 24 WARD)

2-FULL NAME

Leonard Strauss

(a) RESIDENCE. NO.

1508 Boyle

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

2 yrs.

9 mos.

16 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept. 8, 1917

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

9

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto., Md.

10 NAME OF FATHER

Charles C. Strauss

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto., Md.

12 MAIDEN NAME OF MOTHER

Mary M. Herzberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto., Md.

14

Informant (Address)

Charles C. Strauss
1508 Boyle St.

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 24, 1920

17

HEREBY CERTIFY, That I attended deceased from

June 10, 1920, to June 24, 1920,

that I last saw him alive on June 24, 1920,

and that death occurred, on the date stated above, at 6-50 P. M.

The CAUSE OF DEATH* was as follows:

Acute infection

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

deceased heart

(duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. H. Harrison, M. D.

19 (Address) 1340 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cedar Hill Cem.

DATE OF BURIAL

June 26, 1920

20 UNDERTAKER

Margaret G. Flynn

ADDRESS

1422 Light St.

N. B.—WRITE PLAINLY, WITH CARE. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D. 44291

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44291

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sarah Brodbeck(a) RESIDENCE. NO. 1840 St. Fayette ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 7 mos. 4 ds.How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE Wh.5 Single, Married, Widowed, or Divorced (write the word) M5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. E. Brodbeck6 DATE OF BIRTH (month, day, and year) Nov 11 1870

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 49 7 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind.
(State or country)10 NAME OF FATHER Richard Coleman11 BIRTHPLACE OF FATHER (city or town) Ind.
(State or country)12 MAIDEN NAME OF MOTHER Martin Moore13 BIRTHPLACE OF MOTHER (city or town) Ind.
(State or country)

14

Informant Mrs. W. E. Brodbeck
(Address) 1840 St. Fayette St.

15

Filed

Robert P. Harrison, Registrar

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1920

17

I HEREBY CERTIFY, that I attended deceased from May 1st, 1920, to June 25, 1920, that I last saw her alive on June 25, 1920, and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Thyroid - Exophthalmic Goiter

CONTRIBUTORY (Secondary)

(duration)

yrs. 4mos. 10ds. 10

(duration)

yrs.

mos. 2ds. 218 Where was disease contracted if not at place of death? HomeDid an operation precede death? yesDate of 6/25/20Was there an autopsy? noWhat test confirmed diagnosis? Clinical Evidence(Signed) L. Clarence Allen M.D., 19 (Address) St. Agnes' Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL CatholicsDATE OF BURIAL 9/28 192020 UNDERTAKER George A. FisherADDRESS 1 Fayette

D. 44292 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 44292
*91-073

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen Jameson

(a) RESIDENCE. No. Greenbrier, W. Va. ST. Life WARD Greenbrier W. Va.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. Life ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Heiden Jameson (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16 1868

7 AGE 58 Years 8 Months 9 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) W. Va. (State or country)

10 NAME OF FATHER David Jameson

11 BIRTHPLACE OF FATHER (city or town) W. Va. (State or country)

12 MAIDEN NAME OF MOTHER Mertka Walke

13 BIRTHPLACE OF MOTHER (city or town) W. Va. (State or country)

14 Informant Hospital Record (Address) J. H. H.

15 Filed Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920 to June 25, 1920 that I last saw him alive on June 25, 1920 and that death occurred, on the date stated above, at 3:00 PM m.

The CAUSE OF DEATH* was as follows: Peripheral Neuritis

(duration) 1 1/2 yrs. — mos. — ds. CONTRIBUTORY Diaphragmatic Palsy; Broncho (Secondary) Pneumonia (duration) — yrs. — mos. 5 ds.

18 Where was disease contracted Greenbrier, W. Va. if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? none

(Signed) J. Schumacher, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Renick W. Va. DATE OF BURIAL 6/26 1920

20 UNDERTAKER Jack Lewis ADDRESS 1411 E. Baltimore

N. B.—WRITE DATE, NAME, ADDRESS, AND CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCURRENCE IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

D. 44293

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44293

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *1002 Edmondson Ave* St. *16* WARD)2-FULL NAME *Ben Simon*(Residence in Baltimore: No. *1002 Edmondson Ave*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *3* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male*4-COLOR OR RACE, *white*5-SINGLE, *married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, *unknown*, *1871*

(Month)

(Day)

(Year)

7-AGE, *49* yrs. *—* mos. *—* ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *086*(b) General nature of industry, business, or establishment in which employed (or employer), *stocks & bonds*9-BIRTHPLACE, (State or Country), *unknown*10-NAME OF FATHER, *unknown*11-BIRTHPLACE OF FATHER (State or Country), *unknown*12-MAIDEN NAME OF MOTHER, *unknown*13-BIRTHPLACE OF MOTHER (State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Leurs*(Address) *1411 E Baltimore*

15-

Robert P. Harrison,

Filed *JUN 26 1920*

191

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 24, 1920*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *autopsy*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *autopsy*
(Inquest, au-topsy and that said deceased came to *his* death
on the day stated above.

The CAUSE OF DEATH was as follows:

Chronic Refuse Hepatitis(Duration) *—* yrs. *—* mos. *—* ds.CONTRIBUTORY (Secondary) *Acute myocardial dilatation**and coronary sclerosis* (Duration) *—* yrs. *—* mos. *—* ds.(Signed) *J. D. Harrison* M. D.
(Coroner.)*June 25, 1920* (Address) *2802 Edmondson Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death *—* yrs. *—* mos. *—* ds. State *—* yrs. *—* mos. *—* ds.Where was disease contracted, if not at place of death? *—*Former or usual residence *Chicago Ill*19-PLACE OF BURIAL OR REMOVAL, *Chicago Ill*DATE OF BURIAL, *6-27-20*20-UNDERTAKER *Jack Leurs*ADDRESS *1411 E Baltimore*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If signed without state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 44294

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44294

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 914 N. Wolfe ST.: 7 WARD)

2-FULL NAME

Elenora Evans

(Residence in Baltimore: No. 914 N. Wolfe st

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 2 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Aug 23rd, 1920
(Month) (Day) (Year)

7-AGE,

2 yrs., 2 mos., 2 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

none

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

John Evans

11-BIRTHPLACE OF FATHER (State or Country),

Balto.

12-MAIDEN NAME OF MOTHER

Anna Dlenoschuck

13-BIRTHPLACE OF MOTHER (State or Country),

Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Evans

(Address) 914 N. Wolfe st

15-

Robert P. Harrison,

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 25th, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, au-

inquest find that said deceased came to death (Inquest, au-

topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Wm. J. Muley M. D.

6:26 24, 1920 (Coroner) H. F. Slater address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Carmel Ch. June 26, 1920

20-UNDERTAKER

ADDRESS

Geo M. Knicker 811 N. Wolfe st

A44295

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044295

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland Penitentiary* ST.: *16* WARD)

REGISTERED NO. C

2-FULL NAME

William Richardson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *806 Parish* St.: *6* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH

February - 8th, 1904
(Month) (Day) (Year)

7-AGE,

16 yrs. *4* mos. *15* ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*School boy*

9-BIRTHPLACE, (State or Country),

Georgia

10-NAME OF FATHER,

Day Richardson

11-BIRTHPLACE OF FATHER (State or Country),

Georgia

12-MAIDEN NAME OF MOTHER

Susie Ross

13-BIRTHPLACE OF MOTHER (State or Country),

Georgia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Patrick J. Brady

(Address)

Md. Penitentiary

15-

JUN 27 1920

ROBERT B. KRAUTER

Filed

191

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June - 23, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May - 27, 1920*, to *June - 23, 1920*, that I saw him alive on *June - 23, 1920*, and that death occurred, on the date stated above, at *12.25* p.m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs. Cardiac dilatation - Ex. Failure

(Duration) yrs. mos. ds.

CONTRIBUTORY *Bronchopneumonia* (Secondary)

(Duration) yrs. mos. ds.

(Signed) *William H. Schwartz* M. D.*June 23, 1920* (Address) *Maryland Penitentiary*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *8* mos. *20* ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *806 Parish St.*

19-PLACE OF BURIAL OR REMOVAL,

Atlanta Ga

DATE OF BURIAL,

June 26, 1920

20-UNDERTAKER,

David Easley

ADDRESS

916

N. B.—Every item of information should be carefully checked, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044296

1044296

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.)

2-FULL NAME

Mrs. Hilda Greenbaum

(Residence in Baltimore: No.)

1324 E. Lexington

St.; 15 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

November 1899

7-AGE,

21 yrs., mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer)

Housewife, 37

9-BIRTHPLACE,

(State or Country),

Russia

10-NAME OF FATHER,

Meyer Rosen

11-BIRTHPLACE OF FATHER,

Russia

12-MAIDEN NAME OF MOTHER

Fannie Shestern

13-BIRTHPLACE OF MOTHER,

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. Lewis

(Address)

1411 Elizabeth St.

15-

Filed

JUN 27 1920

ROBERT S. KRAUTER

BUTAL PERMIT 1571

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 26, 1920

(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from June 26, 1920, to June 26, 1920,

that I saw her alive on June 26, 1920,

and that death occurred, on the date stated above, 2:10 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Mental Stress & Anxiety

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Disturbance

(Duration) yrs. mos. ds.

(Signed) J. Sack

June 26, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State 12 yrs. mos. ds.

Where was disease contracted, if not at place of death? At home

Former or usual residence 1324 E. Lexington St.

19-PLACE OF BURIAL OR REMOVAL,

Hebrew Southern

20-UNDERTAKER

Jack Lewis

1411 Elizabeth St.

N.B.—Every item of information should be in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is important. See instructions on back of certificate.

1044297

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044297

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

St. Joseph's Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2207 E. Fayette St.

ST.:

WARD)

2-FULL NAME

Jacob Braunstein

(a) RESIDENCE, NO.

2207 E. Fayette St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

30 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Helena Unknown Braunstein

6 DATE OF BIRTH (month, day, and year)

Unknown 1860

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

60

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Peddler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14 Informant (Address)

Helena Braunstein 2207 E. Fayette St.

15 Filed JUN 27 1920

ROBERT E. KLAUTER Registrar

Burial Permit Close

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 25 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 22, 1920, to June 25, 1920,

that I last saw him alive on June 25, 1920,

and that death occurred, on the date stated above, at 9:00 P. M.

The CAUSE OF DEATH* was as follows:

Cellulitis of tongue
duration 0 yrs. 10 mos. 10 ds.

CONTRIBUTORY (Secondary)

Bronchitis pneumonia
duration 0 yrs. 9 mos. 9 ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

H. J. Williams, M. D.

19 (Address)

St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Roadside June 27 1920

20 UNDERTAKER

ADDRESS

Jack Lewis 1411 E. Bacter

Information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
 CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

44298 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044298 CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH 16

CITY OF BALTIMORE: (No. 1611 1/2 Lombard ST. 3 WARD)

2-FULL NAME *Boty Jacobson*

(a) RESIDENCE. NO. 1611 1/2 Lombard ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

15

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

 (If death occurred in
 a hospital or institu-
 tion, give its NAME
 instead of street and
 number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

*White*5 Single, Married, Widowed,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 26 1920

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Balto.*

10 NAME OF FATHER

*Max Jacobson*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Russia*

12 MAIDEN NAME OF MOTHER

*Dora Kaplan*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Russia*

14

Informant
(Address)*Max Jacobson*

15

Filed

*JUN 27 1920*ROBERT E. LAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 26. 1920

17

I HEREBY CERTIFY, That I attended deceased from

, 19, to, 19,

that I last saw her alive on

*June 26. 1920.*and that death occurred, on the date stated above, at *11 a.* m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *H. H. H. H. H.* M. D., 19 (Address) *1810 E. Baltimore St.*
 *State the Disease Causing Death, or in deaths from Violent Causes,
 state (1) Means and Nature of Injury, and (2) whether Accidental,
 Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Alhrev Washington**6/27 1920*

20 UNDERTAKER

John Lewis

ADDRESS

1411 S. E. Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044299 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044299

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1034 Kaling St. 18 WARD)
2-FULL NAME Nelson Stewart
(Residence in Baltimore: No. 1034 Kaling St.; yrs. 40 mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male
4-COLOR OR RACE. Colored
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widowed
6-DATE OF BIRTH. 1 (Month) (Day) (Year)
7-AGE. 63 yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. Auto Helper
(b) General nature of industry, business, or establishment in which employed (or employer). 086

9-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER. Henry Stewart
11-BIRTHPLACE OF FATHER (State or Country). Pennsylvania
12-MAIDEN NAME OF MOTHER. unknown
13-BIRTHPLACE OF MOTHER (State or Country). Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Emma Biggs
(Address). 744 Kaling St.

15-

Filed

JUN 27 1920

ROBERT B. KAUTER

Bureau of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 24, 1910
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) 2 yrs. ... mos. ... ds.

(Signed) James M. Hinton M. D.
(Coroner.)

June 24 1910 (Address) 700 E. Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt Auburn Cemetery June 27 1920

20-UNDERTAKER ADDRESS

A Jones 207 S. Stricker

1044300

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044300

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Slime Court between Brooklyn*
 CITY OF BALTIMORE: (No. *Annapolis & Patuxent Ave.*) ST.; *25* WARD)
 2-FULL NAME *Baby Holmes*
 (Residence in Baltimore: No. *Slime Court - Brooklyn* St.; yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *M.* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) *Single*
 6-DATE OF BIRTH, *June 26th*, 1920
 (Month) (Day) (Year)
 7-AGE, *2* yrs. *15* mos. *15* ds.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work *Infant*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 9-BIRTHPLACE, (State or Country), *Maryland*
 10-NAME OF FATHER, *Wilbert Holmes*
 11-BIRTHPLACE OF FATHER (State or Country), *Maryland*
 12-MAIDEN NAME OF MOTHER, *Mutha Ellen Green*
 13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUN 27 1920

ROBERT H. KAUFER

Filed..... 191

Burial 187th St.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 26th*, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 26*, 1920, to *June 26*, 1920, that I saw him alive on *June 26*, 1920, and that death occurred, on the date stated above, at *1:30 p.m.*
 The CAUSE OF DEATH* was as follows:

Premature birth
 (Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Geo. B. Davis* M. D.
June 27, 1920 (Address) *211 Church St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

JOHN F. DENNY

715 LIGHT ST.

N.B.—Every item of information should be in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *M.D. Marine Hospital* ST. *5* WARD)2-FULL NAME *Andrew Wormley*(a) RESIDENCE. NO. *1424 Mulliken St.* ST. *5* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. *1* mos. *1* ds.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*None*6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE

25

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

*JUN 27 1920*ROBERT H. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 25th 1920*17 I HEREBY CERTIFY, That I attended deceased from *May 24th 1920* to *June 25th 1920*, that I last saw him live on *June 25th 1920*, and that death occurred, on the date stated above, at *8:30 A.M.*

The CAUSE OF DEATH* was as follows:

*General Tuberculosis
Pneumonia
Sputum*

CONTRIBUTORY (Secondary)

Asthma

18 Where was disease contracted If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed)

Chas. A. Mages

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*White Horse
Lancaster Va**June 25th 1920*

20 UNDERTAKER

Chenoweth & Son

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Precise statement of OCCUPATION is very important. See instructions on back of certificate.

1044302 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044302

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 3424 Ash. ST. 13 WARD
CITY OF BALTIMORE (No. 3424 Ash. ST. 13 WARD)
2-FULL NAME Evelyn Bowen
(Residence in Baltimore: No. 3424 Ash. ST. St.; yrs. mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-SINGLE Single
6-DATE OF BIRTH Sept. 2, 1920
7-AGE 4 yrs. 4 mos. 24 ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country) Balt Md
10-NAME OF FATHER Eugene Bowen
11-BIRTHPLACE OF FATHER Ind
12-MAIDEN NAME OF MOTHER Alice Chilesat
13-BIRTHPLACE OF MOTHER Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Bowen
(Address) 3424 Ash ST

15-ROBERT E. KRAUTER
Filed JUN 27 1920 191 REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH June 26, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, a copy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Parasomnia
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
(Signed) J. H. H. M. D.
(Address) 8632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ADDRESS
St Marys Hospital June 28 1920
20-UNDERTAKER
Chenoweth Son Chestnut Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

1844304

64 1844304

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 648 Raborg ST. 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas. Johnson(Residence in Baltimore: No. 648 Raborg St. 2 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male4-COLOR OR RACE. C5-SINGLE, Mar
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH. July 4, 1912

(Month)

(Day)

(Year)

7-AGE 27 yrs. 11 mos. 11 ds.

If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Journalist
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or County). Charlotte N. C.10-NAME OF FATHER. John Johnson11-BIRTHPLACE OF FATHER. Ill. Know12-MAIDEN NAME OF MOTHER. John Johnson13-BIRTHPLACE OF MOTHER. Ill. Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Johnson(Address) 648 Raborg

15-

Filed

JUN 27 1920

191

ROBERT E. KRAFTER

Burial Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 23, 1912

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from June 14, 1912, to June 23, 1912,that I saw h. alive on June 23, 1912, and that death occurred, on the date stated above, at 9:30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) yrs. mos. ds. 10CONTRIBUTORY (Secondary) Feeling ill(Duration) yrs. mos. ds. 1(Signed) J. H. Johnson M. D.June 23, 1912 (Address) 737 N. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Laural Bury June 26, 1920

20-UNDERTAKER

ADDRESS

Daniel Easton Baltimore

N.B.—Every return must be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. *John Hopkins Hospital* ST.: *16th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Bernadine Dondiken*(a) RESIDENCE. NO. *1040 H. W. Smith St. Baltimore Md.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

Life mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *7*6 DATE OF BIRTH (month, day, and year) *Dec. 15, 1919*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *6 11*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md.* (State or country)10 NAME OF FATHER *Charles Dondiken*11 BIRTHPLACE OF FATHER (city or town) *Maryland* (State or country)12 MAIDEN NAME OF MOTHER *Margaret Love*13 BIRTHPLACE OF MOTHER (city or town) *Maryland* (State or country)14 Informant *J. H. H.* (Address)15 *JUN 27 1920*ROBERT E. ELSTED
Registrar
Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 26 1920*17 I HEREBY CERTIFY, That I attended deceased from *June 26th*, 1920, to *June 26th*, 1920, that I last saw her alive on *June 26th*, 1920, and that death occurred, on the date stated above, at *1* P. m.

The CAUSE OF DEATH* was as follows:

hæmoperal diptheria(duration) yrs. mos. *28* ds.CONTRIBUTORY *Lobar pneumonia* (Secondary)(duration) yrs. mos. *4* ds.

18 Where was disease contracted

if not at place of death? *unknown*Did an operation precede death? *See* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *throat cultures - ulcers*(Signed) *William Christian*, M. D., 19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral *June 28 1920*

20 UNDERTAKER ADDRESS

Marion Kahney & Sons 1827 N. York

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044307

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044307

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1410 Division

ST. 14

WARD)

2-FULL NAME

William L. Smith

(Residence in Baltimore: No. 1410 Division Dr.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

36 St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUN 27 1920

ROBERT B. KRAUTER

Official Public Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an

thereon and from the evidence obtained by said

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

CONTRIBUTORY (Secondary)

(Signed) J. A. Hennessy M. D.

(Coroner.) June 26, 1920 (Address) 2802 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

1044308

HEALTH DEPARTMENT—CITY OF BALTIMORE

No. 44308

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hosp. 19

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

Louis Fredrick

(a) RESIDENCE.

No. 1517 Lennon

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

40

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Col

5 Single, Married, Widowed,
or Divorced (write the word)

Married.

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Sachie Fredrick

6 DATE OF BIRTH (month, day, and year)

Richmond

7 AGE

66

Years

Months

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Laborer 040

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Street worker.

(c) Name of employer

City

9 BIRTHPLACE (city or town)

Md.

(State or country)

10 NAME OF FATHER

Fred Fredrick

11 BIRTHPLACE OF FATHER (city or town)

Md.

(State or country)

12 MAIDEN NAME OF MOTHER

E. Barnes

13 BIRTHPLACE OF MOTHER (city or town)

Md.

(State or country)

14

Informant
(Address)Hospital Records
University Hosp.

15

JUN 27 1920

ROBERT E. KRAUTER

Registrar

Baltimore Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 25 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 11, 1920, to June 25, 1920

that I last saw him alive on June 24, 1920.

and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Pernicious
Anemia

(duration) — yrs. 10 mos. 24 ds.

CONTRIBUTORY
(Secondary)

Cardiac Distention

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Ralph E. Duncan, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Bur

June 28 1920

20 UNDERTAKER

Daniel E. Easton

ADDRESS

Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE:

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

15 yrs

mos.

ds.

How long in U. S., if of foreign birth

Life yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

JUN 27 1920

ROBERT I. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 22, 1920, to Jan 26, 1920.

that I last saw him alive on Jan 26, 1920.

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Anger's Pestis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? m Date of

Was there an autopsy? m

What test confirmed diagnosis?

(Signed) J. M. D.

1920 (Address) 16 v Bently

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF DEATH is very important. See instructions on back of certificates.

Dr. Valentini 16 S. Bently.

10.44310 HEALTH DEPARTMENT—CITY OF BALTIMORE 108 10.44310

CERTIFICATE OF DEATH.
 1-PLACE OF DEATH *Biddle & Telford Sanatorium*
 CITY OF BALTIMORE: NO. *2724 N. Charles* ST.: *12* WARD)
 2-FULL NAME *Raymond Spencer Clarke*
 (a) RESIDENCE. NO. *2537 St Paul* ST.: _____ WARD. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred *4* yrs. mos. ds. How long in U. S., if of foreign birth? *4* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS
 3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*
 5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____
 6 DATE OF BIRTH (month, day, and year) *May 21-1892*
 7 AGE Years *28* Months *1* Days *3* If LESS than 1 day, hrs. or min.
 8 OCCUPATION OF DECEASED
 (a) Trade, profession or particular kind of work *Travelling Salesman*
 (b) General nature of industry, business, or establishment in which employed (or employer) *066*
 (c) Name of employer _____
 9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*
 10 NAME OF FATHER *Spencer Clarke*
 11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *Maryland*
 12 MAIDEN NAME OF MOTHER *Dora Price*
 13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *Maryland*

14 Informant *Dora Price Clarke* (Address) *2537 St Paul St*
 15 Filed *JUN 27 1920* ROBERT E. KRAUTER Registrar
 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH
 16 DATE OF DEATH (month, day, and year) *June 24* 19*20*
 17 I HEREBY CERTIFY, That I attended deceased from *June 23rd*, 19*20*, to *June 24th*, 19*20*, that I last saw him alive on *June 24th*, 19*20*, and that death occurred, on the date stated above, at *5:15 P.* m. The CAUSE OF DEATH* was as follows:
Chronic Appendicitis
 (duration) yrs. mos. ds.
 CONTRIBUTORY *✓* (Secondary) (duration) yrs. mos. ds.
 18 Where was disease contracted *New York, NY* if not at place of death?
 Did an operation precede death? *Yes* Date of _____
 Was there an autopsy? *no*
 What test confirmed diagnosis? *✓*
 (Signed) *August Horn*, M. D.
 , 19 (Address) *40 E. 25th St*
 *State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Louder Park Cemetery* DATE OF BURIAL *June 28* 19*20*
 20 UNDERTAKER *H E Hughes* ADDRESS *17 Broadway*

Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. EARLY MENTION OF TION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

044311 HEALTH DEPARTMENT—CITY OF BALTIMORE 169 1044311

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Lower yard.
CITY OF BALTIMORE (No Baltimore Dry docks & Ship Bldg 3. WARD)
2-FULL NAME Gaetano Amicone.
(Residence in Baltimore: No. 911 Fawn St. St.; yrs. 7 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married. (Write the word.)

6-DATE OF BIRTH, February 11th, 1896, 1 (Month) (Day) (Year)

7-AGE, 24 yrs. 4 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Italy.

10-NAME OF FATHER, Dominic Amicone.

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER, Angelen Rasetta.

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Louis Amicone. (brother) (Address) 500 S. Exeter St.

15- JUNE 28 1920 BOBBE K. KRAUTER Registrar. Filed 191

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 25th, 1920, 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above. The CAUSE OF DEATH* was as follows:

Accidental Drowning. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) Otto M. Remhard (Coroner) June 27 1920 (Address) 1917 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Holy Redeemer Ch. June 2, 1920

20-UNDERTAKER, ADDRESS, Wendell Lippert & Son 27 S. ...

944312 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: *4* WARD)

2-FULL NAME

Isaac Smith

(a) RESIDENCE. NO.

New Windsor

ST.: *New Windsor* WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

6

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mrs. Clara Smith

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

71 years

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

A. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

B. Eiter

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Geo E. Smith

New Windsor Md

15

JUN 28 1920

ROBERT B. KRAUTER Registrar

Barial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6/27/20

17

I HEREBY CERTIFY, That I attended deceased from

6/21

19 *20*, to

6/27

19 *20*.

that I last saw him alive on

6/27

19 *20*.

and that death occurred, on the date stated above, at

m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

CONTRIBUTORY (Secondary)

Stone (duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

6/27/20

(Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Windsor

DATE OF BURIAL

6/30 1920

20 UNDERTAKER

H. Bankard & Son

ADDRESS

Westminster

Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

944312

123

N. B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044313. HEALTH DEPARTMENT—CITY OF BALTIMORE 1044313.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 105 E. Barney St. St. 24 WARD)

2-FULL NAME Maria G. Feduccia.

(Residence in Baltimore: No. 105 E. Barney St.

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

21 St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married. (Write the word.)

6-DATE OF BIRTH, November 15th, 1857, 1 (Month) (Day) (Year)

7-AGE, 62 yrs. 7 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Italy.

10-NAME OF FATHER, Luigi Di Stefano.

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER, Maria Girdina.

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pasquale Feduccia. (husband)

(Address) 105 E. Barney St.

15-

JUN 28 1920.

101

ROBERT E. KRAUTER

BURIAL PLACE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 26th, 1920, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Pennington, M. D.

June 27, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Vincent's Ave

JUN 28 1920

UNDERTAKER

ADDRESS

Geo. J. Ruth.

1735 Harford Ave

10-44314

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 44314

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

312 Emory.

ST.;

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

M. C. Jones

(a) RESIDENCE. NO.

312 Emory

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred • yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mch. 1920.

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Ismael Winstead

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Ada Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

Ada Jones
312 Emory St.

15

JUN 28 1920

ROBERT E. FLAHERTY
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 26 1920

17

HEREBY CERTIFY, That I attended deceased from June 22, 1920, to June 26, 1920, that I last saw him alive on June 25, 1920, and that death occurred, on the date stated above, at 12 m. The CAUSE OF DEATH* was as follows:

Enterocolitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

6-27-1920 Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western

DATE OF BURIAL

June 28 1920

20 UNDERTAKER

Edmond Tontore

ADDRESS

12-14
N. Street

CAUSE OF DEATH IN plain terms, so far as possible, on back of certificates. See instructions on back of certificates.

1044315

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044315

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1113 William

ST.;

WARD)

REGISTERED NO. C

2-FULL NAME

Wilhelmina Wentworth

(Residence in Baltimore: No.

1113 William

St.;

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

May 11th, 1886

(Month)

(Day)

(Year)

7-AGE

34

yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer)

Housewife

9-BIRTHPLACE,
(State or Country),

Baltimore Md

10-NAME OF
FATHER,

Hugo Zinkand

11-BIRTHPLACE
OF FATHER
(State or Country),

Germany

12-MAIDEN NAME
OF MOTHER

Charlotte Miller

13-BIRTHPLACE
OF MOTHER
(State or Country),

German

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Alexander Wentworth

(Address)

1113 William St

15-

Filed

JUN 28 1920

ROBERT B. KLAUTER

Burial from Hospital

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June

28th

1920

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on June 17th, 1920,

and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Val. Dis. of heart (Mitral)

(Duration) 18 yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Asphyxiation

(Duration) 18 yrs. 18 mos. ds.

(Signed) M. D.

June 26, 1920 (Address) 607 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,

state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or

HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Goudon Park

DATE OF BURIAL,

June 28, 1920

20-UNDERTAKER

E and B Harle

ADDRESS

115 E. North St.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

1044316

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044316

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 N. Bond

ST.: 8 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clinton B. Parry

(Residence in Baltimore: No. 1811 N. Bond

St.; 70 yrs., 10 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Aug 10, 1849

(Month)

(Day)

(Year)

7-AGE,

70 yrs., 10 mos. 15 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

Carpenter

9-BIRTHPLACE, (State or Country),

Baltimore Md.

10-NAME OF FATHER,

Cyrus Parry

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Elizabeth

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. Louisa Parry

(Address)

1811 N. Bond

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 25, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Feb 15 1920, to June 25 1920,

that I saw him alive on June 25 1920,

and that death occurred, on the date stated above, at 5:15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease of Heart

(Duration) 5 yrs. 10 mos. 15 ds.

CONTRIBUTORY (Secondary)

(Duration) 5 yrs. 10 mos. 15 ds.

(Signed)

Walter Thomas M. D.

June 26 1920 (Address) 1228 Cedar Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Baltimore Cemetery June 28, 1920

20-UNDERTAKER

ADDRESS

John O. Mitchell 120 N. W. Taylor

CAUSE OF DEATH in plain terms, so that it may be properly transmitted important. See instructions on back of certificate.

15- JUN 28 1920

ROBERT B. KRAUTER

Baltimore City Health Department

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION ESSENTIAL. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

10. 44317

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044317

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. (yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUN 28 1920

191

ROBERT B. KRAUTER
BUTLER PUBLIC HEALTH REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Accidental Choking at
Stair - due to fall from
balcony 8 ft at top
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed)

(Coroner)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

644318

HEALTH DEPARTMENT—CITY OF BALTIMORE

644318

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

810 O'Baro St.

ST.

3

WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Thomas Mastal

(Residence in Baltimore: No.

810 O'Baro St.

St.; yrs., 2 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

April 6, 1920

(Month)

(Day)

(Year)

7-AGE,

2 yrs., 20 mos., 20 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Independent

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Peter Mastal

11-BIRTHPLACE OF FATHER (State or Country),

Galicia

12-MAIDEN NAME OF MOTHER

Mary

13-BIRTHPLACE OF MOTHER (State or Country),

Galicia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Mastal

(Address)

810 O'Baro St.

15-

Filed

JUN 28 1920

ROBERT A. ELLIOTTER

Baltimore

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 26, 1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Heavy Shaw

June 26, 1920 (Address) 1614 E. Bay St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Rosary

June 28, 1920

20-UNDERTAKER

ADDRESS

J. H. Fiacconi 1418 Eastern Ave.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 W. Pratt ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander B. Bulach(a) RESIDENCE. No. 16 W. Pratt ST. 4 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None6 DATE OF BIRTH (month, day, and year) Oct 19, 1861

7 AGE

Years 58Months 8

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md10 NAME OF FATHER Jacob Bulach11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md12 MAIDEN NAME OF MOTHER Isabelle Allen13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14

Informant (Address) Joseph M. Bulach
16 W. Pratt

15

JUN 28 1920

ROBERT B. KROGER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1920

17

HEREBY CERTIFY, That I attended deceased from Dec 31 1919 to June 26 1920, that I last saw him alive on June 25 1920and that death occurred, on the date stated above, at 9.30 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) George M. Smith M. D.Tr. 1920 (Address) George M. Smith

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

BaltimoreJune 29 1920

20 UNDERTAKER

ADDRESS

Woolcock 102 E. North

10 44320 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1237 E Eager)

ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary M. Scheel

(a) RESIDENCE

No. 1237 E Eager

ST.: 10 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

61 yrs 1 mos 13 ds

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Nicholas M. Scheel

6 DATE OF BIRTH (month, day, and year)

May 13 1859

7 AGE

Years

Months

Day

If LESS than

1 day, hrs.

or min.

61

1

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 137

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

John Hamper

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margaret Vogler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant

(Address)

Mr. Nicholas M. Scheel

1237 E Eager St

15

Filed

JUN 28 1920

ROBERT B. FRANKS

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 26 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 1916 to June 26 1920

that I last saw him alive on

June 19 1920

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Rheumatic fever

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Dilatation of heart, caused

by initial rheumatic fever

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George A. Martignon, M. D.

(Address) 2214 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cemetery

June 30 1920

20 UNDERTAKER

Henry Hock Law

ADDRESS

1301 E Eager St

1044322

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044322

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

Jews Hopkins Hospital ST. 17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Berlie Chambers

(a) RESIDENCE. NO.

2003 Hargrove Alley ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

Life

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

+

6 DATE OF BIRTH (month, day, and year)

Jan 5-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

John Chambers

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

2003 Hargrove Alley

15

Filed

JUN 28 1920

ROBERT E. KRAUTER

Registrar

BALTIMORE CITY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 27-1920

17

I HEREBY CERTIFY, That I attended deceased from

May 6, 1920, to June 27, 1920,

that I last saw him alive on June 27, 1920,

and that death occurred, on the date stated above, at 10:42 a.m.

The CAUSE OF DEATH* was as follows:

Congenital hydrocephalus (operation)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-2-20

Was there an autopsy? Yes

What test confirmed diagnosis? operation

(Signed) Catherine C. C. M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Cemetery June 28 1920

20 UNDERTAKER

ADDRESS

JAMES H. DENNIS

1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

1044323

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044323

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

Mrs. Hoof

ST.: 3

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Harry Aymann

(a) RESIDENCE. No.

1104 E. Lombard

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 6

mos.

ds.

How long in U. S., if of foreign birth?

yrs. 6

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto.

10 NAME OF FATHER

Harry Aymann

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Mollie?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Harry Aymann
1104 E. Lombard St.

15

Filed

19

JUN 28 1920

REGISTERED

BUTLER FARMER OLC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6 27 1920

17

I HEREBY CERTIFY, That I attended deceased from

6, 20, 1920, to 6, 27, 1920.

that I last saw him alive on 6, 27, 1920.

and that death occurred, on the date stated above, at 11, 30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Gastro-Enteritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry A. Aymann M. D.

(Address) Mrs. Hoof

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Burial Rd

June 28, 1920

20 UNDERTAKER

Sol Greenberg

ADDRESS 1127

E Balto.

1044324 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044324

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Md. General Hospital* ST.: *27* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary E. Winter

(a) RESIDENCE. No.

29 E Woodland Ave.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. — mos. — ds. How long in U. S., if of foreign birth? *68* yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Henry Winter*6 DATE OF BIRTH (month, day, and year) *Apr 26 1851*7 AGE Years *68* Months *6* Days *1* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Winchester Va.

10 NAME OF FATHER

Charles Bellrich

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Catherine Rindgen

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

F. D. Winter 29 E Woodland Ave

15

Filed

JUN 28 1920

ROBERT E. FRUTTER

Registrar

Basil Pearl Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 27 1920*

17

I HEREBY CERTIFY, That I attended deceased from

June 22 1920, to *June 27 1920*,that I last saw her alive on *June 27 1920*,and that death occurred, on the date stated above, at *9:09 a. m.*

The CAUSE OF DEATH* was as follows:

General Carcinomatosis (gall bladder, stomach & bowel)(duration) *1* yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? *29 E Woodland Ave.*Did an operation precede death? *yes* Date of *June 23, 1920*Was there an autopsy? *no*What test confirmed diagnosis? *operation*(Signed) *F. E. Wright* M. D.*127*, 1920 (Address) *Md. General Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Landon Park Cemetery**June 29 1920*

20 UNDERTAKER

W. M. Roulton

ADDRESS

225 E 1st St. with Mary

Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044325 Preston W. Bursler HEALTH DEPARTMENT—CITY OF BALTIMORE 1044325

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *University Hospital* ST.: *4* WARD) REGISTERED No. C
2-FULL NAME *Preston Wilson Bursler*
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(Residence in Baltimore: No. *Hampstead Canal Co no 51* St.: yrs. mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
(Write the word.)
6-DATE OF BIRTH, *Dec 13, 1913*
(Month) (Day) (Year)

7-AGE, *6* yrs. *6* mos. *14* ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *school*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *MD*

PARENTS.
10-NAME OF FATHER, *Bernard Bursler*
11-BIRTHPLACE OF FATHER (State or Country), *MD*
12-MAIDEN NAME OF MOTHER, *Jessie Zeffs*
13-BIRTHPLACE OF MOTHER (State or Country), *MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Bernard Bursler*
(Address) *Hampstead Md*

15-
Filed *JUN 28 1920* 191 *BOBERT S. BRADY*
Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan 27, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an...
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said...
(Inquest, au-
topsy or inquiry.) and that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

From wounds in his side & abdomen due to falling on pipe for
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) *fall from head of hay*
(Duration) yrs. mos. ds.
(Signed) *H. J. Gorman* M. D.
(Coroner.)
6-28-1920 (Address) *117 W. Saratoga*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place In the
of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.
Where was disease contracted/ If not at place of death?

Former or usual residence *Hampstead Md*

19-PLACE OF BURIAL OR REMOVAL, *Wesley Chapel Md* DATE OF BURIAL, *July 1, 1920*

20-UNDERTAKER *Wm. R. Rouse* ADDRESS *238 N. North Ave*

1044326 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044326

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

JUN 28 1920

101 ROBERT R. KRAUTER

Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an..... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, au-

topsy or inquiry.) And that said deceased came to..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbolic acid poisoning, accidental

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

(Coroner.).....Address.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place..... In the of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST.: *8th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elmer Sadler(a) RESIDENCE. NO. *2114 Kuper St.* ST.: _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

+

6 DATE OF BIRTH (month, day, and year)

June 27-1918

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*2**—**—*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

C. Aided.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore**MD.*

10 NAME OF FATHER

Andrew Sadler

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Margaret Grady

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

J. H. Brevard

15

JUN 28 1920

ROBERT H. TRAUBER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 27-1920

17

I HEREBY CERTIFY, That I attended deceased from

*June 24, 1920, to June 27, 1920,*that I last saw him alive on *June 27, 1920,*and that death occurred, on the date stated above, at *12:20 p.m.*

The CAUSE OF DEATH* was as follows:

meningococcus meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

none (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? *2114 Kuper Street*Did an operation precede death? *no* Date of _____Was there an autopsy? *no*What test confirmed diagnosis? *humbar puncture*(Signed) *Carlton C. Clegg*, M. D.19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cathedral Ave**June 28 1920*

20 UNDERTAKER

ADDRESS

Chas. H. Evans & Son 118 North Royal Ave.

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

1044328

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1044328

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 Warren Ave ST.: 24 WARD)

2-FULL NAME Martha Jane Granger

(a) RESIDENCE. No. 223 Warren Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of Lewis J. Granger

6 DATE OF BIRTH (month, day, and year) 7-18-1845

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 74 11 8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER William B. Joyner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER Emily Meekins

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14 Informant (Address) Robert H. Krautler 223 Warren Ave

15 Filed JUN 28 1920 ROBERT H. KRAUTLER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1920

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1914, to June 26, 1920,

that I last saw him alive on June 26, 1920,

and that death occurred, on the date stated above, at 8:40 P. M.

The CAUSE OF DEATH* was as follows:

over

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Bampton, M. D.

627, 1920 (Address) 307 E. Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

LOUDON PARK

JUN 29 1920

20 UNDERTAKER JOHN F. DENNY

ADDRESS 716 LIGHT ST.

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Houswife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Toxemia due to
uremia.
Chronic nephritis
No hemorrhage.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *20 South Carrollton Ave.* ST. *18* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

20 South Carrollton Ave. ST. *18* WARD.
(Usual place of abode) (If nonresident give city or town and State)Length of residence in city or town where death occurred *33* yrs. *11* mos. *15* ds. How long in U. S., if of foreign birth? *53* yrs. *11* mos. *ds.*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of *John W. Groener*6 DATE OF BIRTH (month, day, and year) *July 2, 1867*7 AGE Years *53* Months *11* Days *25* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

JUN 28 1920

ROBERT E. LEAVELLE

Registrar

BRIEF PERMIT CLERK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 27th 1920*17 I HEREBY CERTIFY, That I attended deceased from *May 1st*, 19 *20*, to *June 27th*, 19 *20*, that I last saw her alive on *June 27th*, 19 *20*, and that death occurred, on the date stated above, at *2:45 p.m.*
The CAUSE OF DEATH* was as follows:*Acute dilatation of the Heart.*CONTRIBUTORY *Chronic Interstitial Nephritis* (duration) *4* yrs. *1* mos. *1* ds. (2)

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical & Laboratory Ex.*(Signed) *Benjamin H. Smith* M. D., 19 (Address) *1206 W. North Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**June 30 1920*

20 UNDERTAKER

Edgar Smith

ADDRESS (1000)

H. Payette

This information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

644330

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 St. Monroe ST.; 15 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1810 St. Monroe St. 70 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Widow

6-DATE OF BIRTH,

Nov 12, 1842
(Month) (Day) (Year)

7-AGE,

77 yrs. 7 mos. 14 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country)

Waterford Ireland

10-NAME OF FATHER,

Richard Knox

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Anastasia McPawley

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas. G. Cooper

(Address)

1113 N. Mulberry St.

16-

JUN 28 1920 ROBERT E. KRAUTER

Filed 191. BUREAU OF PUBLIC HEALTH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jul 26, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 15, 1920, to June 26, 1920,

that I saw him alive on June 26, 1920,

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) 3 yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary) Coma, Acute Dehydration

(Duration) 3 yrs. 3 mos. 3 ds.

(Signed) J. H. Thomas, D.

June 27, 1920 (Address) 1228 N. Carroll

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Sandown Park

DATE OF BURIAL,

June 29, 1920

20-UNDERTAKER

George Smith

ADDRESS 1000 N. ...

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530, W Biddle ST.: 17 WARD)2-FULL NAME Benjamin Wright(a) RESIDENCE. No. 530 W Biddle ST., 17 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE C 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Wright6 DATE OF BIRTH (month, day, year) May 20, 18617 AGE Years 59 Months 1 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver. Local Wagon(b) General nature of industry, business, or establishment in which employed (or employer) Stamley(c) Name of employer George Schumacher9 BIRTHPLACE (city or town) (State or country) Virginia10 NAME OF FATHER Benjamin Wright11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia12 MAIDEN NAME OF MOTHER Abigail Smith13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia14 Informant Julia Wright (Address) 530 W Biddle15 Filed JUN 28 1920 ROBERT B. KLAUTER Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 192017 I HEREBY CERTIFY, That I attended deceased from March 4, 1920, to June 25, 1920, that I last saw him alive on June 25, 1920, and that death occurred, on the date stated above, at 10.55 P. m. The CAUSE OF DEATH* was as follows:Cerebral Hemorrhage. (duration) yrs. mos. ds. CONTRIBUTORY Arterio Sclerosis (Secondary) (duration) yrs. 3 mos. ds.18 Where was disease contracted if not at place of death? yesDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical(Signed) Wm H Wright, M. D.Address 1709 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dan Cemetery DATE OF BURIAL June 28, 192020 UNDERTAKER John H Owens ADDRESS 578 York

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1201 Argyle Ave.* ST. *17* WARD)

2-FULL NAME

Catherine M. Smith

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE

No. *1201 Argyle Ave.* ST. *17* WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2* yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mr. Thomas Smith

6 DATE OF BIRTH (month, day, and year)

12-25-1874

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*45**7*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

At home

(c) Name of employer

Myself

9 BIRTHPLACE (city or town) (State or country)

Williamport Md.

10 NAME OF FATHER

George Pulpus

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Harriett Clarke

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Williamport Md.

14

Informant (Address)

Mr. Ida Pierre (sister) Williamport Md.

15

Filed

19

*JUN 28 1920**ROBERT E. ERADTER*
Registrar*Burial permit 0122*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 25 1920

17

I HEREBY CERTIFY, That I attended deceased from *June 19*, 19*20*, to *June 24*, 19*20*, that I last saw her alive on *June 24*, 19*20*.and that death occurred, on the date stated above, at *12 P.* m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis(duration) yrs. mos. *8* ds.

CONTRIBUTORY (Secondary)

Intestinal Putrefaction
(duration) yrs. mos. *5* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical exam.*(Signed) *William H. Harris*, M. D.*6/27, 1920* Address) *1200 Penn. Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mount Airy**June 29 1920*

20 UNDERTAKER

ADDRESS

*John H. Owens**538*
Dolphin

CAUSE OF DEATH in plain terms, so that it may be properly transcribed. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

244333

CERTIFICATE OF DEATH.

7120 244333

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes' Hospital*)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

60 yrs.

mos.

ds.

How long in U. S. If of foreign birth?

60 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

Wh.

5 Single, Married, Widowed, or Divorced (write the word)

Widower

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Mary A. Murphy

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

JUN 28 1920

ROBERT E. KILPATRICK

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6-28 1920

17

I HEREBY CERTIFY, That I attended deceased from

4-29, 1920, to 6-28, 1920

that I last saw him alive on 6-28, 1920

and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Prostatic hypertrophy

(duration) 5 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Chronic nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

Yes

Date of

May 6, 1920

Was there an autopsy?

No

What test confirmed diagnosis? Operation - lab. findings

(Signed) L. Clarence Coker, M. D.

19 (Address) St. Agnes' Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

6/30 1920

20 UNDERTAKER

ADDRESS

Henry W. Mears & Son 805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

10.44334

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.44334

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *936 E near*ST.: *10* WARD)

2-FULL NAME

John DeLuca(a) RESIDENCE. No. *936 E near*

(Usual place of abode)

ST.,

WARD.

Length of residence in city or town where death occurred

yrs. *6*

mos.

ds. How long in U. S., if of foreign birth?

yrs. *6*

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 13/1899

7 AGE

Years

Months

Days

8 LESS than

1 day, hrs.

or min.

*6**15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore*

10 NAME OF FATHER

*Adolph DeLuca*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Italy*

12 MAIDEN NAME OF MOTHER

*Ethel Allen*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Baltimore*

14

Informant
(Address)*Adolph DeLuca*
936 E near St

15

Filed *JUN 28 1920*

ROBERT E. KENNEDY

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 28 1920

17

I HEREBY CERTIFY, That I attended deceased from

*June 24, 1920, to June 27, 1920,*that I last saw him alive on *June 27 1920,*and that death occurred, on the date stated above, at *4 a* m.

The CAUSE OF DEATH* was as follows:

*Erysipelas**4 days*(duration) yrs. mos. *4* ds.CONTRIBUTORY
(Secondary)*Pulmonary Congestion*(duration) yrs. mos. *1* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Physical exam*(Signed) *Maurice J. DeLuca*, M. D., 19 (Address) *2328 Madison Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Vincent's Cemetery June 28 1920

20 UNDERTAKER

ADDRESS

Wm. Bachlor & Son

CAUSE OF DEATH in plain terms, so that it may be properly transcribed. See instructions on back of certificates.

10.44335 HEALTH DEPARTMENT—CITY OF BALTIMORE

10.44335

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE NO. 910 Poplar Grove 16 WARD)

2-FULL NAME James A. Fluit Sr

(a) RESIDENCE. NO. 910 Poplar Grove WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (Write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Fluit

6 DATE OF BIRTH (month, day, and year) Aug 3-1850

7 AGE Years 69 Months 10 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Station Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Radio Sock Exchange

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER James A. Fluit

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Anna M. Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) 910 Poplar Grove

15 Filed JUN 28 1920 ROBERT E. KRAMER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27 1920

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1920 to June 27, 1920, that I last saw him alive on June 27, 1920, and that death occurred, on the date stated above, at 11:55 a.m.

The CAUSE OF DEATH* was as follows:

Acute Infectious Pharyngitis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted ? if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) H. C. Grant, M. D.

, 19 (Address) 1207 Poplar Grove.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

burial (date) 6/30 1920

20 UNDERTAKER ADDRESS

William Cook 5076 N. Oak

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificate.

1044336

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044336

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *U.S. Marine Hospital* REGISTERED NO. *28*
 CITY OF BALTIMORE: (No. *U.S. Marine Hospital* ST. *WARD*)
 2-FULL NAME *Albert Green*
 (a) RESIDENCE. NO. *U.S. Marine Hospital* ST. *WARD*
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*
 5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Unmarried*
 6 DATE OF BIRTH (month, day, and year) *Unknown*
 7 AGE Years Months Days If LESS than 1 day, hrs. or min. *63*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Seaman* 086
 (b) General nature of industry, business, or establishment in which employed (or employer) *on board ship*
 (c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Maryland*
Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*

14

Informant *U.S. Marine Hospital*
 (Address)

15

Filed *JUN 28 1926*

ROBERT A. ALLEN
 Registrar

BURIAL PERMIT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 26 1926*

17

I HEREBY CERTIFY, That I attended deceased from *6/21*, 19*26*, to *6/26*, 19*26*, that I last saw him alive on *6/26*, 19*26*, and that death occurred, on the date stated above, at *9:35 P.M.*

The CAUSE OF DEATH* was as follows:

Chronic fulminant tuberculosis

(duration) *1 1/2* yrs. mos. ds.
 CONTRIBUTORY *Tuberculosis of larynx*
 (Secondary) (duration) yrs. 3 mos. ds.

18 Where was disease contracted *Ship board*
 If not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *yes*

What test confirmed diagnosis? *Plautopsy 7213*
 (Signed) *A. D. Deschard* M. D.

(Address) *U.S. Marine Hospital, Baltimore*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Woodlawn June 28 1926

20 UNDERTAKER

ADDRESS

Chenoweth & Son Chestnut

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 N. Chester ST.; 7 WARD)

REGISTERED NO. C

2-FULL NAME

Sophia Sericor

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 516 N. Chester St.; 6 yrs., 6 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

F.

4-COLOR OR RACE,

W5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.) S

6-DATE OF BIRTH,

Nov - 27, 1919
(Month) (Day) (Year)

7-AGE,

6 yrs., 20 mos. 20 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer).

rooming9-BIRTHPLACE,
(State or Country),City

PARENTS.

10-NAME OF FATHER,

James Sericor11-BIRTHPLACE OF FATHER
(State or Country),Greece

12-MAIDEN NAME OF MOTHER

Ada Dr. Goltis13-BIRTHPLACE OF MOTHER
(State or Country),Greece

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Sericor(Address) 516 N. Chester St.

15-

ROBERT B. KRAUTER

Filed

JUN 28 1920

191

Baltimore City Health Department Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

6 - 27 - 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

6-25-1920, to 6- 1920.that I saw her alive on 6-27-1920.and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

acute lobar pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)acute lobar pneumonia(Signed) J. A. Summary M. D.6-28-1920 (Address) 1604 E. Linden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Woodlawn

DATE OF BURIAL

June 28 1920

20-UNDERTAKER

Philip Henry

ADDRESS

2016 Orleans St.

CAUSE OF DEATH in plain terms important. See instructions on back of certificate.

1044338

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044338

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2223 E. Fayette ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Adam Griese

(a) RESIDENCE. NO.

2223 E Fayette ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widower

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Louise Griese

6 DATE OF BIRTH (month, day, and year)

Apr 7/44

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

76

2

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Shoe Maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Henry Griese

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Maggie McGuire 2228 W. Linwood

JUN 28 1920

ROBERT B. KRAUTER

Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1920

17

HEREBY CERTIFY, that I attended deceased from June 24, 1920, to June 27, 1920.

that I last saw him alive on June 27, 1920.

and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

senile debility

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Grand Constriction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. M. M. D.

164, 1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cem.

June 30 1920

20 UNDERTAKER

Philip Herwig

ADDRESS

2016 Orleans

D. 44339 HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44339

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2033 St. Claire ST.; WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 2033 St. Claire ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha J. Dare

6 DATE OF BIRTH (month, day, and year) Sept 15 1845

7 AGE Years 74 Months 9 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER William Dare

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Martha J. Dare (Address) 2033 St. Claire Lane

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1920

17 I HEREBY CERTIFY, That I attended deceased from 6/5/20, 19, to 6/27/20, 19, that I last saw him alive on 6/27/20, 19, and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows:

Senility of old age

CONTRIBUTORY (Secondary)

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. S. Simon, M. D.

, 19 (Address) 3528 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

Fiskler & Fiskler Address 1739 Eager

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

JUN 28 1920

1044340

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044340

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3807 Fernwood Ave. ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Virginia F. Smith

(a) RESIDENCE. NO.

3807 Fernwood Ave. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

Married to
Conrad Smith

6 DATE OF BIRTH (month, day, and year)

Aug 2- 1861

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.581024

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Wm. Morningstar

11 BIRTHPLACE OF FATHER (city or town) (State or country)

York, Penna.

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not known

14

Informant
(Address)Conrad Smith3807 Fernwood Ave.

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 26 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 1, 1919, to June 26, 1920,that I last saw her alive on June 25, 1920,and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

arterio Sclerosis Primary(duration) 6 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary)

Cerebral Haemorrhage(duration) 1 yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Place of deathDid an operation precede death? no Date of noWas there an autopsy? no

What test confirmed diagnosis?

Physical Examination

(Signed)

J. L. Burke

M. D.

, 19

(Address)

3042 Hudson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Carmel CemeteryJune 29 1920

20 UNDERTAKER

Girkler + Girkler

ADDRESS

1739 E. Egan St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

JUN 28 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2732 Dillon*)2-FULL NAME *Gertrude Vonau*(a) RESIDENCE. NO. *2732 Dillon*

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

*White*5 Single, Married, Widowed,
or Divorced (write the word)*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Nov. 11. 1841.*

7 AGE

78

Years

7

Months

16

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*At home*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Austria*10 NAME OF FATHER *Wm. J. Vonau*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Austria*12 MAIDEN NAME OF MOTHER *Margaret B. Conrad*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)14 Informant
(Address)*John Conrad
935 S. Linwood Ave
Robert P. Harrison,*

Registrar

15

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)ST.: *1* WARD)

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? *30* yrs. - mos. - ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 27 1920*

17 I HEREBY CERTIFY, That I attended deceased from

*June 23 1920 to June 27 1920*that I last saw her alive on *" 27 1920*and that death occurred, on the date stated above, at *12:12 A. m.*

The CAUSE OF DEATH* was as follows:

*Pleumy*CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?*at home*

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Physical signs

(Signed)

E. S. Ober

M. D.

19 (Address)

*408 S. Pratt Ave**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oaklawn

20 UNDERTAKER

Gibbler + Gibbler

DATE OF BURIAL

June 29 1920

ADDRESS

1739 Eager

10.44342.

HEALTH DEPARTMENT—CITY OF BALTIMORE

No. 44342

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2139 E. Oliver ST.; 8 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2139 E. Oliver ST.; 3 yrs., 2 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Single

6-DATE OF BIRTH,

April 14, 1917

(Month)

(Day)

(Year)

7-AGE,

3 yrs., 2 mos., 14 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, business, or establishment in which

employed (or employer).

9-BIRTHPLACE,
(State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

Joseph H. Rice, Jr.

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Alice L. Marks

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joseph H. Rice, Jr.

(Address)

2139 E. Oliver

15-

FILE

8-1020

191

Robert P. Harrison,

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 28, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 27, 1920, to June 28, 1920,

that I saw him alive on June 28, 1920,

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis (not epidemic)

30 hours

(Duration) 30 hours

CONTRIBUTORY

(Secondary) none

(Duration) yrs. mos. ds.

(Signed) J. M. Harrison M. D.

June 28, 1920 (Address) 2128 St. Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Baltimore

DATE OF BURIAL,

June 29, 1920

20-UNDERTAKER

Pickler & Pickler

ADDRESS 1239

Eager

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7278204 ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Edward Parker(Residence in Baltimore: No. 7278204 ST.; 9 WARD)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH.

September 181898

(Month)

(Day)

(Year)

7-AGE,

21 yrs. 9 mos. 10 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Student

(b) General nature of industry, business, or establishment in which employed (or employer).

ADD

9-BIRTHPLACE,

(State or Country).

Baltimore, Md

10-NAME OF FATHER.

John E. Parker

11-BIRTHPLACE OF FATHER

(State or Country)

Brooklyn, N.Y.

12-MAIDEN NAME OF MOTHER

Margaret G. Parker

13-BIRTHPLACE OF MOTHER

(State or Country).

Baltimore, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John E. Parker

(Address)

7278204

15-

June 8, 1920 Robert P. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June271920

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 12, 1918, to June 27, 1920, that I saw him alive on June 26, 1920, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Infection(Duration) 2 yrs. 1 mos. 25 ds.

CONTRIBUTORY (Secondary)

Exhaustion(Duration) 2 yrs. 1 mos. 7 ds.

(Signed)

P. E. Lilly

M. D.

June 20, 1920 (Address) John E. Parker, Inc.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 21 yrs. 9 mos. 10 ds. In the State 21 yrs. 9 mos. 10 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

New Catholic Ad. June 29, 1920

20-UNDERTAKER

ADDRESS

George J. Ruth 1735 Hayford Ave.

CAUSE OF DEATH in plain terms so that it may be properly important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 44344 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 44344

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1509 McHenry ST. 19 WARD)

FULL NAME

(Residence in Baltimore: No. 1509 McHenry

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Life St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH

X September 6, 1918 (Month) (Day) (Year)

7-AGE,

1 yrs. 9 mos. 20 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Balt City

10-NAME OF FATHER,

Edward J. Kelly

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore Md

12-MAIDEN NAME OF MOTHER

Mabel Cooper

13-BIRTHPLACE OF MOTHER (State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward J. Kelly

(Address) 1509 McHenry

15-

Filed JUN 23 1920 Robert P. Harrison,

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 26, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said investigation

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Crushed Chest & internal hemorrhage caused by fall from fence passing over the Chest Oblique Fracture of Ribs

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Harrison M. D. (Coroner.)

June 26 1920 (Address) 705 E. Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Linden Park Burial June 29, 1920

20-UNDERTAKER

ADDRESS

Joseph Syfer 1609 N. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44345

D44345

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Little Sisters of the Poor

REGISTERED No. C

CITY OF BALTIMORE: (No.

ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Rose Tierney

(Residence in Baltimore: No.

Little Sisters of the Poor

St.: 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-MARRIAGE

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Wid.

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

80

yrs.

mos.

da.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Ireland

10-NAME OF FATHER,

Christopher Meenan

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Mary Meenan

13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Sister Benedict

(Address)

Little Sisters of the Poor

15-

Robert P. Harrison,

JUN 8 1920

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 28, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

to record

191

to

191

that I saw her alive on

June 27, 1920

and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

Unknown (Duration)....yrs.....mos.....ds.

CONTRIBUTORY

(Secondary)

.....(Duration)....yrs.....mos.....ds.

(Signed).....F. A. Turner.....M. D.

June 28, 1920 (Address) 1133 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place

of death

yrs.

3

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cathedral

DATE OF BURIAL,

June 29, 1920

20-UNDERTAKER

H. C. Riedfeldt

ADDRESS

1133 Valley St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs. Anna Welby

(a) RESIDENCE. NO.

701 Laura St.

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1867

7 AGE 53 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Mrs. Welby
701 Laura St.

15

File

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1920

17 I HEREBY CERTIFY. That I attended deceased from June 19, 1920, to June 27, 1920, that I last saw her alive on June 27, 1920, and that death occurred, on the date stated above, at 10 30 P m. The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds. 3

CONTRIBUTORY (Secondary)

Acute appendicitis
(duration) yrs. mos. ds. 2

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death? yes Date of June 19-20

Was there an autopsy?

no

What test confirmed diagnosis?

operation

(Signed) David Miller, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

July 1 1920

20 UNDERTAKER

H. C. Medfield 914

CAUSE OF DEATH in plain terms, so that it can be understood by the layman. See instructions on back of certificates.

JUN 28 1920

10.44347 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.44347

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 543 Sunvale ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Milton Alton Davis

(a) RESIDENCE. No.

543 Sunvale

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

24 yrs.

2 mos.

22 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 24, 1896

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

or min.

24

24

2

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Ex. Soldier, Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

W. S. Army -

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Henry Davis

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Annapolis Md

12 MAIDEN NAME OF MOTHER

Mamie Graham

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Essex Co. Va.

14

Informant

(Address)

Henry Davis

543 W. Sunvale

15

Filed

JUN 28 1920 Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 27 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 11, 1920, to June 21, 1920,

that I last saw him alive on June 20, 1920,

and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

W. S. Camp,

Did an operation precede death?

No

Date of

Was there an autopsy?

No

Bureau

What test confirmed diagnosis?

Physical - Tubercle

(Signed)

William H. Wright, M. D.

1920 (Address) 1209 Presstman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Auburn

June 29 1920

20 UNDERTAKER

ADDRESS

John H. Green

538 2nd

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

D. 444348 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Jones Hopkins Hospital ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carmier Daniecki(a) RESIDENCE. NO. 509 S. Collington Ave.WARD. 1st

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

X

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

15312

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Printers Apprentice

(b) General nature of industry, business, or establishment in which employed (or employer)

Office Boy - 063

(c) Name of employer

The Hub.

9 BIRTHPLACE (city or town) (State or country)

Baltimore -

10 NAME OF FATHER

Jacob Daniecki

11 BIRTHPLACE OF FATHER (city or town)

Poland -

(State or country)

12 MAIDEN NAME OF MOTHER

Josephine Jankowski

13 BIRTHPLACE OF MOTHER (city or town)

Poland -

(State or country)

14

Informant (Address)

Joseph Daniecki 7077 records
509 S. Collington Ave.

15

Filed

Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 24, 1920, to June 28, 1920,that I last saw him alive on June 28, 1920,and that death occurred, on the date stated above, at 11:20 A.M.

The CAUSE OF DEATH* was as follows:

Dysentery -
(Bacillary?)(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

at home -Did an operation precede death? No Date ofWas there an autopsy? No -

What test confirmed diagnosis?

inconclusive Bacterial culture

(Signed)

John A. Lee

M. D.

, 19

(Address)

Jones Hopkins Hosp. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary Cem.7/1 1920

20 UNDERTAKER

ADDRESS

Stephen J. Sialkowski1000 V. Kenwood

CAUTION is very important. See instructions on back of certificates.

JUN 28 1920

D.44349

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.44349

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital WARD)2-FULL NAME Frank Bartkowiak

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 1006 Harrison Alley ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life unknown yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town)
(State or country) Maryland10 NAME OF FATHER Joseph Bartkowiak11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany12 MAIDEN NAME OF MOTHER Anthonia Modlineski13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany14 Informant Hospital Records
(Address) M.T.H.15 Filed 1920 Robert P. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 18th, 19 20, to June 26, 19 20, that I last saw him alive on June 25, 19 20, and that death occurred, on the date stated above, at 8.30 A. M.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) yrs. 9 mos. ds.CONTRIBUTORY Encephalitis
(Secondary)(duration) yrs. 4 mos. ds.18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis T.B. in sputum.(Signed) George A. Wilkinson, M. D.26-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Saint Stanislaus 6/29 1920

20 UNDERTAKER

ADDRESS

Stephen J. Fidkowski 1000 S. Kenwood

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

244350 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1017 Binnery St.)

ST. 1

WARD)

2-FULL NAME

(Residence in Baltimore: No. 1017 Binnery St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

Yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

101

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

mediation find that said deceased came to death (Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion of the Brain

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner.)

June 28, 1920

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

44351 HEALTH DEPARTMENT—CITY OF BALTIMORE 44351

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes' Hospital*)2-FULL NAME *Joseph Braumbart*(a) RESIDENCE. No. *1012 Primrose St*

(Usual place of residence)

Length of residence in city or town where death occurred *6* yrs. *3* mos. *12* ds.

WARD.

(If nonresident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 COLOR OR RACE *W*5 Single, Married, Widowed, or Divorced (write the word) *Chief*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *none*6 DATE OF BIRTH (month, day, and year) *March 14 1914*7 AGE Years *46* Months *3* Days *12* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) *Chief*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ind*10 NAME OF FATHER *John Braumbart*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ind*12 MAIDEN NAME OF MOTHER *Maria Sitteria*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ind*14 Informant (Address) *Mrs. John Braumbart 1012 Primrose Ave*15 Filed *19* Robert F. Harrison, Registrar

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *6-26 1920*17 I HEREBY CERTIFY, That I attended deceased from *6-6*, 19*20*, to *6-26*, 19*20* that I last saw him alive on *6-26*, 19*20* and that death occurred, on the date stated above, at *11:15 P.M.*The CAUSE OF DEATH* was as follows: *Pyemia - Multiple Abscesses*CONTRIBUTORY (Secondary) *Broncho-pneumonia* (duration) *21* yrs. *21* mos. *21* ds.18 Where was disease contracted *at home* If not at place of death?Did an operation precede death? *Yes* Date of *6/8/20*Was there an autopsy? *No*What test confirmed diagnosis? *Chinl. date - X-ray*(Signed) *Clarence Cohen*, M. D.19 (Address) *St. Agnes' Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Cross Cem. *June 29 1920*

20 UNDERTAKER ADDRESS

M. J. Flynn *1422 Light*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 28 1920

D. 44352

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44352

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 Union Ave. 13

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1012 Union Ave.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH.

Sept 12, 1920
(Month) (Day) (Year)

7-AGE,

4 yrs. 16 mos. 16 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Balt. City

PARENTS.

10-NAME OF FATHER,

Norman B. Noel

11-BIRTHPLACE OF FATHER
(State or Country),

Balt. City

12-MAIDEN NAME OF MOTHER

Esther Rowe

13-BIRTHPLACE OF MOTHER
(State or Country),

Balt. City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Norman B. Noel

(Address)

1012 Union Ave.

15-

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 28, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 5, 1920, to June 28, 1920,

that I saw him alive on June 28, 1920,

and that death occurred, on the date stated above, at 3:00 p. m.

The CAUSE OF DEATH* was as follows:

Leukemia

(Duration) ... yrs. ... mos. ... ds. 5

CONTRIBUTORY
(Secondary)

Tubercular Meningitis

(Duration) ... yrs. ... mos. ... ds. 18

(Signed)

R. P. Harrison M. D.

June 28, 1920 (Address) 3447 Chestnut St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

20-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Trinity Reform Church July 19, 1920

21-UNDERTAKER

ADDRESS

H. H. Marshall 3537 Fall Rd

important. See instructions on back of certificate.

JUN 28 1920

0.44353 HEALTH DEPARTMENT—CITY OF BALTIMORE 9/44353 CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3212 North Ave ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 3212 North Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 18 1918

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14

Informant (Address)

15

Burial

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-27 1920

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1920, to June 27, 1920, that I last saw him alive on June 27, 1920, and that death occurred, on the date stated above, at 11.15 P. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Walter C. Bacon, M. D.

6/28/20 (Address) 100 E 20th St Baltimore

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OF REMOVAL DATE OF BURIAL

6/30/20

ADDRESS

2606 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. List statement of cause of death on back of certificate. Important. See instructions on back of certificate.

1477
D. 44354

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D. 44354
167

PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Joseph Hospital* ST. *7* WARD)

FULL NAME

Marie A. Minnich

(Residence in Baltimore: No. *518 N. Rose St.*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *Life* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Widow

6-DATE OF BIRTH

Don't know, 18*32*
(Month) (Day) (Year)

7-AGE

87 yrs. mos. ds.

If LESS than 1 day,
hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

At Home
000

9-BIRTHPLACE (State or Country)

Md.

10-NAME OF FATHER

Peter Parks

11-BIRTHPLACE OF FATHER (State or Country)

Md.

12-MAIDEN NAME OF MOTHER

Angeline Treadwell

13-BIRTHPLACE OF MOTHER (State or Country)

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Betty Foster

(Address)

Tomboon

15-

Robert P. Harrison,

PH-*8-1920*

101

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH

Jan 27 19K0
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

opsy or inquiry.) and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns, scalding caught fire while burning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner)

191 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Chestnut Ridge Cem.

DATE OF BURIAL

June 29 1920

20-UNDERTAKER

Wm Cook

ADDRESS

502 E. North

10. 44355

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

10 44355

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 Ensor St

ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Bosley

(a) RESIDENCE. No. 811 Ensor St

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female Colored

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Married

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

25 Years

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Born in Baltimore
Lived in Baltimore

10 NAME OF FATHER

Preston Bosley

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Born in Baltimore

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant

(Address)

Charlie Bosley

811 Ensor St

15

JUN 29 1920

ROBERT B. KAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 26-1920

17

I HEREBY CERTIFY, That I attended deceased from

May 3 - 1920, to June 26, 1920.

that I last saw her alive on June 25, 1920.

and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Haemorrhage of lungs

Tuberculosis of lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Tuberculosis of lungs

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. G. W. Kennard, M. D.

6-26-1920 Address 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn Cemetery

June 29, 1920

20 UNDERTAKER

Mrs. R. A. Elliott

ADDRESS 1725-

Ashland

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

10.44356

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.44356

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 781 W Saratoga

ST. 4

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Addison Brown

(Residence in Baltimore: No. 781 W Saratoga St.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widower

6-DATE OF BIRTH,

Don't Know, 1

(Month)

(Day)

(Year)

7-AGE,

74 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE, (State or Country),

Md.

10-NAME OF FATHER,

Don't Know

11-BIRTHPLACE OF FATHER (State or Country),

Don't Know

12-MAIDEN NAME OF MOTHER

Don't Know

13-BIRTHPLACE OF MOTHER (State or Country),

Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILED

JUN 29 1920

191

ROBERT E. LAUTER

Special Police Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 28, 1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said

(Inquest, autopsy, or inquiry.)

and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

From history of disease
Chronic nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. J. Gossinger, M. D.

(Coroner.)

6128, 1920 Address 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Auburn

June 29 1920

20-UNDERTAKER

ADDRESS 916

Daniel E. Carter

Ba an

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044357

1044357

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bayview Hospital

REGISTERED NO.

37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 20 WARD

2-FULL NAME

Jennie M. Meloh.

(a) RESIDENCE. No.

6 S. Pulaski

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

25 yrs.

How long in U. S., if of foreign birth?

Unknown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Arthur K. Meloh

6 DATE OF BIRTH (month, day, and year)

1889

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

31.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Austria

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Austria

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Austria

14

Informant (Address)

Bayview Hosp. Bkts, Md.

15

Filed

JUN 29 1920

ROBERT E. KRAUTER Registrar

Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 27, 1920

17

I HEREBY CERTIFY. That I attended deceased from

April 20, 1918, to June 27, 1920.

that I last saw him alive on June 27, 1920.

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

CONTRIBUTORY (Secondary)

Typhoid

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Phys. + Serological

(Signed)

H. Goldsmith M. D.

(Address)

Bayview Hosp.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Henry Burial

6-29-20

20 UNDERTAKER

ADDRESS

Jack Lewis, 1411 E. Bala

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

10 44358

10 44358

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2824 Box 17

2-FULL NAME

(a) RESIDENCE. NO. 2824 Box

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs.

mos.

ds. How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Lucy J. Hatchett

6 DATE OF BIRTH (month, day, and year)

1862

7 AGE

58

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

Day Laborer

(c) Name of employer

B & O R. R.

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Henry Hatchett

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Lucy J. Hatchett

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14 Informant (Address)

Beoni Hatchett 318 N. 28 St.

15 Filed

19

ROBERT E. KRAETTER

JUN 29 1920

Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 26 1920

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1920, to June 26, 1920, that I last saw him alive on June 26, 1920, and that death occurred, on the date stated above, at 10:40 a.m. The CAUSE OF DEATH* was as follows:

Myocarditis (Chronic). Indefinite

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. G. Russell, M. D.

Address 1534 N. H. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL

DATE OF BURIAL

Laurel Park

June 29 1920

20 UNDERTAKER

ADDRESS

Samuel J. Hensley 378 N. H. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

444359

HEALTH DEPARTMENT—CITY OF BALTIMORE

44359

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 Oxford ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 572 Oxford ST. 17 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred (60) mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dead

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE 81 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince Geo. Co. Md.

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14

Informant (Address)

15

Filed

JUN 29 1920

ROBERT B. KAUFER Registrar

Serial Permit Class

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27/1920

17

I HEREBY CERTIFY, That I attended deceased from

May 5, 1920, to June 27, 1920

that I last saw him alive on June 26, 1920

and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

Uremia

CONTRIBUTORY (duration) yrs. mos. ds.

(Secondary) 5 or 6 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Jno. H. Thompson, M. D.

(Address) 1019 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Bowie Md.

20 UNDERTAKER

Samuel Hensley

DATE OF BURIAL

June 27 1920

ADDRESS

5700 Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

1044360

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Arthur Page
184 N. Caroline

(a) RESIDENCE. NO.

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

19

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Laborer

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

Sparrows Point

9 BIRTHPLACE (city or town)
(State or country)

Buckingham Va

10 NAME OF FATHER

John Page

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Buckingham Va

12 MAIDEN NAME OF MOTHER

Bessie Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Warsaw Va.

14

Informant
(Address)Wm. Rollins
Buckingham Va

15

Date

JUN 29 1920

ROBERT E. ELSTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1920

17

I HEREBY CERTIFY, That I attended deceased from
June 23, 1920, to June 27, 1920,

that I last saw him alive on June 27, 1920,

and that death occurred, on the date stated above, at I P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration)

yrs.

mos.

3

ds.

Lobar Pneumonia

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

9

ds.

18 Where was disease contracted

if not at place of death?

No

Did an operation precede death?

No

Was there an autopsy?

What test confirmed diagnosis? Physical signs

(Signed)

J. B. Bronushas

M. D.

6-28 1920 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Farmville Va.

June 29 1920

20 UNDERTAKER

Leo. G. Cook

ADDRESS

Northwood

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates.

44361 HEALTH DEPARTMENT—CITY OF BALTIMORE 44361

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St. John, Hosque* ST. *5* WARD)

2-FULL NAME *Jessie Grant*

(Residence in Baltimore: No. *1405 Asque Alley,* St. *50* yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*

4-COLOR OR RACE, *Col.*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*

6-DATE OF BIRTH, *1* (Month) (Day) (Year)

7-AGE, *61* yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Domestic*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Unknown*

10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER (State or Country), *Unknown*

12-MAIDEN NAME OF MOTHER, *Bessie Fowler*

13-BIRTHPLACE OF MOTHER (State or Country), *Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Grant*

(Address) *1435 Argyle Ave.*

15-

JUN 29 1920

ROBERT F. KRAUTER

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 22*, 19*20*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained *in said* (Inquest, au-

and that said deceased came to death *on the day stated above.*

The CAUSE OF DEATH* was as follows:

Pneumonia, 1st stage
in yard (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *J. J. Dusen*

(Coroner.)

101... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mt Auburn*

DATE OF BURIAL, *June 30 1920*

20-UNDERTAKER

Milton Davis

ADDRESS

411 N. Edinboro

N. B.—Every item of information furnished on this certificate is important. See instructions on back of certificate.

1044362

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044362

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 155)

ST.

WARD)

FULL NAME

(Residence in Baltimore: No. 1705 in Park St.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country)

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUN 29 1920

ROBERT B KRAUTER

191

BALTIMORE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) M. D.

6-28-1920 Address

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death....yrs....mos....ds. State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificate.

1044364 *Spanish* HEALTH DEPARTMENT—CITY OF BALTIMORE 1044364
182

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *in Spanish Cemetery*) *17* WARD)

2-FULL NAME *Jose Eduard Sorunich*

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *712 W muddy st,* *Life* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male* 4-COLOR OR RACE, *colored* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH, *Oct.* *1880*
(Month) (Day) (Year)

7-AGE, *39* yrs. *0* mos. *0* ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Laborn*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Ind.*

10-NAME OF FATHER, *Thomson*

11-BIRTHPLACE OF FATHER (State or Country), *va.*

12-MAIDEN NAME OF MOTHER, *Eliz Cooper*

13-BIRTHPLACE OF MOTHER (State or Country), *Mo*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Maggie Ganett*
(Address) *712 W muddy st*

15- *RUN 29 1920* *ROBERT B. KAUTER*
FILED *191* *DEPT. OF HEALTH*
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jan* *25*, *1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy ~~examination~~)
thereon and from the evidence obtained by said.....
(Inquest, au-
topsy or ~~inquiry~~) and that said deceased came to *his* death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Bullet wounds in his
abdomen & liver.
(Duration).....yrs. *a family* mos. ds.

CONTRIBUTORY *shot by Mrs. Thomas*
(Secondary) *a family*

(Signed) *H. K. Gorman* M. D.
(Coroner.)
6129, 1020 (Address) *1117 W. Saratoga*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, *Mt Auburn* DATE OF BURIAL, *June 30, 1920*

20-UNDERTAKER *Farmer & Wm 13641 Carey* ADDRESS

100 dup
CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter statement of cause of death on back of certificate. See instructions on back of certificate.

244365 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓
CERTIFICATE OF DEATH.
PLACE OF DEATH
CITY OF BALTIMORE (No. 1375 Woodman St. 15 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Ella Coates
(Residence in Baltimore: No. 1375 Woodman St. St.: yrs., 4 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female	4-COLOR OR RACE. Black	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married
6-DATE OF BIRTH February 4, 1920 (Month) (Day) (Year)		
7-AGE. 4 yrs., 4 mos., 24 ds.		If LESS than 1 day, ...hrs. or ...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Sei-faut		
9-BIRTHPLACE, (State or Country). Balt. Md.		
PARENTS.	10-NAME OF FATHER. Spencer Coates	
	11-BIRTHPLACE OF FATHER (State or Country). Wash. D. C.	
	12-MAIDEN NAME OF MOTHER Rosie Snell	
	13-BIRTHPLACE OF MOTHER (State or Country). Balt. Md.	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Rosie Coates
(Address) 1375 Woodman St.

16- JUN 29 1920
17- ROBERT B. KRAUTER
18- BRITISH PATENT OFFICE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.
January 28, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
(Duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY
(Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) J. D. ... M. D.
(Coroner.)
(Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place In the
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn	DATE OF BURIAL. Jan 29 1920
20-UNDERTAKER Edw. Klinggold	ADDRESS 1463 Carey

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44366.

CERTIFICATE OF DEATH.

79 D 44366
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

410 W 23rd St. 12 WARD)

2-FULL NAME

I da Florence Trimble

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

410 W 23rd St. WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

40 yrs

mos.

ds.

How long in U. S., if of foreign birth?

40 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

(or) WIFE of

Thomas B Trimble

6 DATE OF BIRTH (month, day, and year)

April 19, 1863

7 AGE

57

Years

2 Months

9 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

Housekeeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore County, Md

10 NAME OF FATHER

Joseph P. Hoshall

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Martha W. Bull

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Thos B Trimble
410 W 23rd

15

Filed

JUN 29 1920

ROBERT E. ELLIOTT

BRIEF FINAL CLERK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 14, 1920, to June 28, 1920.

that I last saw her alive on June 28, 1920.

and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart
(Mitral Valve Insufficiency)

(duration)

3 yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Exophthalmic Goiter

(duration)

39 yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation & Percussion

(Signed)

6/29/20 (Address)

J. H. H. M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Fondren Park Bur July 19 1920

20 UNDERTAKER

ADDRESS

M. Cook N. H. H.

1044367

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.44367

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1640 E Monument ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Nellie Brown

(a) RESIDENCE

No. 1640 E Monument ST.

WARD.

Columbus Ohio

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

8

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

colored

5 Single. Married. Widowed. or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

married

6 DATE OF BIRTH (month, day, and year)

June 26 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

43

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Columbus Ohio

10 NAME OF FATHER

John Wiggins

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ohio

12 MAIDEN NAME OF MOTHER

Eliza Wiggins

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ohio

14

Informant (Address)

Arthur Banks 1640 E Monument St.

15

JUN 29 1920

ROBERT E. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 26 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 26 1920, to June 26 1920,

that I last saw him alive on June 26 1920,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

apoplexy

4 or 5 hours

(duration)

CONTRIBUTORY

(Secondary)

Epilepsy

(duration)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. Edwards Fisher, M. D.

19

(Address)

1612 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Columbus Ohio

June 29 1920

20 UNDERTAKER

Mrs J. G. Locks

ADDRESS

1302 Jeff.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

1044368

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044368

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2109 Essex

ST.;

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Felicia Kamienski

(a) RESIDENCE. NO.

2109 Essex

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 20 1920

7 AGE

Years

Months

Days

If LESS than 1 day,.....hrs. or.....min.

— 5 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Wladyslaus Kamienski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Felicia Bruska

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Wladyslaus Kamienski 2109 Essex

15

JUN 29 1920

ROBERT E. KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6/29 1920

17

I HEREBY CERTIFY, That I attended deceased from

6/25, 1920, to 6/28, 1920

that I last saw him alive on 6/27, 1920,

and that death occurred, on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Bunch Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 7.4 Date of

Was there an autopsy? No

What test confirmed diagnosis? Sigm 98 syphilin

(Signed) H. A. Bunch, M. D.

, 1920 (Address) 1623 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary Cemetery

June 30 1920

20 UNDERTAKER

ADDRESS

John M. Weber 1803 Bank St

CAUSE OF DEATH. See instructions on back of certificates.

L 44369

HEALTH DEPARTMENT—CITY OF BALTIMORE

L 44369

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *None*)ST.: *+*WARD: *+*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *Simon W. Va.*ST.: *+*WARD: *Putnam W Va*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar. 3, 1914

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1**5**26*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

W. Va.

10 NAME OF FATHER

Manson Arnold

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Penn

12 MAIDEN NAME OF MOTHER

Genevieve Lee

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Penn

14

Informant (Address)

Robert E. Krutter

15

FILE

JUN 29 1920

Robert E. Krutter

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 24 1920

17

I HEREBY CERTIFY, That I attended deceased from

*6/22 1920 to 6/24 1920*that I last saw him alive on *6/24 1920*and that death occurred, on the date stated above, at *W. Va.* m.

The CAUSE OF DEATH* was as follows:

Second Degree Burn of Face, Arms & Body(duration) yrs. mos. *20* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of *6/24 1920*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Wm. D. Ridgely* M. D.6/4/1920 (Address) *W. Va.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Putnam W. Va**6/29 1920*

20 UNDERTAKER

ADDRESS

Wm. D. Ridgely

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

1044370

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 1044370

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603, S. Bond, ST.; 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Heroin Zurek

(a) RESIDENCE. NO.

603, S. Bond ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Chiles

6 DATE OF BIRTH (month, day, and year)

Sept 7 - 1948

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

10

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Peter Zurek

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Lorathes Kubiak

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

L. Zurek 603 S. Bond

15

JUN 29 1920

ROBERT B. KEAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 29 1920

17

I HEREBY CERTIFY, That I attended, deceased from

June 26, 1920, to June 29, 1920,

that I last saw him alive on June 28, 1920,

and that death occurred, on the date stated above, at 6 am.

The CAUSE OF DEATH* was as follows:

Dysentery.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. C. Gladys, M. D.

, 19 (Address) 143 H. Pirray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross

6/30 1920

20 UNDERTAKER

William Fialkowski Eastern Ave.

D. 44371

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44371

91-078

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Josephs Hospital* ST.: *26* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Irene Cumberland

(a) RESIDENCE. NO.

816 S. Bouldin St. ST. 26 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *5* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 19 - 1913

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*7**3**8*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Co Md.

10 NAME OF FATHER

George J. Cumberland

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Co Md.

12 MAIDEN NAME OF MOTHER

Catharine Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Co Md.

14

Informant (Address)

George J. Cumberland 816 S. Bouldin St. Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6-27 1920

17

I HEREBY CERTIFY, That I attended deceased from

*June 25, 1920, to June 27, 1920,*that I last saw her alive on *June 27, 1920,*and that death occurred, on the date stated above, at *3:10 a.m.*

The CAUSE OF DEATH* was as follows:

Emphysema - Right side only (followed pneumonia as far as can be determined) not known about 7 weeks

CONTRIBUTORY (Secondary)

Myocardial insufficiency

18 Where was disease contracted

if not at place of death?

Not known

Did an operation precede death?

yes Date of 6/27/20

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

W. B. Elwyn

M. D.

19

(Address)

St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Sacred Heart Cem.**June 30 1920*

20 UNDERTAKER

Lilly and Zuber

ADDRESS

403 S. Wolfe St.

CAUSE OF DEATH IN BACK OF CERTIFICATE. See instructions on back of certificates.

JUN 29 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44372

D. 44372

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Union Protestant Infirmary

REGISTERED NO. C

CITY OF BALTIMORE: (No.

1514 Division

ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Richard D. Sang (LANG)

(Residence in Baltimore: No.

2206 Barclay Street

St.; 38 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

February

29th

1860

(Month)

(Day)

(Year)

7-AGE,

60 yrs. 4 mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

West Virginia

10-NAME OF FATHER,

Theodore F. Sang.

11-BIRTHPLACE OF FATHER
(State or Country),

W. Va.

12-MAIDEN NAME OF MOTHER

Susan Fowler

13-BIRTHPLACE OF MOTHER
(State or Country),

W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Hospital Record

(Address)

15-

Robert P. Harrison,

191

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 29th

(Month)

(Day)

1920

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from

June 24th 1920, to June 29th 1920,that I saw him alive on June 29th 1920,

and that death occurred, on the date stated above, at 4:45 a.m.

The CAUSE OF DEATH* was as follows:

General Sarcinomatosis

(Duration).....yrs....5...mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....J. M. H. Finney, Jr. M. D.

June 29th, 1920 (Address) Union Protestant Infirmary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos....5...ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? At home.

Former or usual residence 2206 Barclay St., Baltimore, Md.

19-PLACE OF BURIAL OR REMOVAL,

Druid Ridge Cemetery

DATE OF BURIAL,

7/1....., 1920

20-UNDERTAKER

Henry W. Mears & Son 805 N. Calvert

ADDRESS

St.

important. See instructions on back of certificate.

JUN 29 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.....)

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

...St.; yrs., *nine* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE.

5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

8-DATE OF BIRTH.

7-AGE, Wife said 49, LWS 54, ~~if~~ LESS than 1 day,

S-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country).

10-NAME OF
FATHER,

**11-BIRTHPLACE
OF FATHER**
(State or Country).

12-MAIDEN NAME
OF MOTHER

**13-BIRTHPLACE
OF MOTHER
(State or Country).**

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Mrs. V. V. V.

(Address).....

15-

Robert P. Harrison,
Filed 9-9-1920, 191.....

UN 2 9 1920 Burial Permit C19 Registrar.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH,

17- I HEREBY CERTIFY, That I took charge of the
remains described above, held an.....*inquest*.....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... *Agent*

.....and that said deceased came to.....death
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed).....M. D.

....., 191..... (Address)..... 1039 Buoy.....

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE, (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place _____ In the _____
of death....yrs.....mos.....ds. State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

20-UNDERTAKER

DATE OF BURIAL.

ADDRESS

D. 44374

HEALTH DEPARTMENT—CITY OF BALTIMORE

10. 44374

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2050 Hanover ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 2050 Hanover ST., 23 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Wm P. Frailey

6 DATE OF BIRTH (month, day, and year) Jan 8 1857

7 AGE Years 63 Months 19 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt. Md.

10 NAME OF FATHER

John Hamburg

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Austman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant (Address) Frank Frailey 2050 Hanover St.

15 Filed Jun 29 1920 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1919, to June 27, 1920, that I last saw him alive on June 27, 1920, and that death occurred, on the date stated above, at 10 P. M. The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) uremia (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically (Signed) R. H. Campbell, M. D.

28, 1920 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cedar Hill Cem.

June 30 1920

20 UNDERTAKER ADDRESS M. G. Lynn 1422 Light

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. _____)

ST. 18 WARD)

REGISTERED NO. C _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. _____)

St.: _____ yrs. 7 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH.

Nov

23

1919

(Month)

(Day)

(Year)

7-AGE,

7

mos.

6

ds.

If LESS than 1 day,

...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Chief

9-BIRTHPLACE,
(State or Country).

Laurel Md.

10-NAME OF FATHER,

Marshall Lyman

11-BIRTHPLACE OF FATHER
(State or Country).

Howard Co. Maryland

12-MAIDEN NAME OF MOTHER

Minnie Lyman

13-BIRTHPLACE OF MOTHER
(State or Country).

Howard Co. Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUN 29 1920

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June

29

191...

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I saw her alive on June 28, 1919,

and that death occurred, on the date stated above, at 6:15 p. m.

The CAUSE OF DEATH* was as follows:

Heart Prostration

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. J. Fingloss M. D.

6/29, 1919 (Address) Murray & Child's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Landon Park

June 30, 1919

20-UNDERTAKER

ADDRESS

Geo. Smith

Fayett a

important. See instructions on back of certificate.

D.44376

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.44376

CERTIFICATE OF DEATH.

175-001

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is not important. See instructions on back of certificate.

PLACE OF DEATH
CITY OF BALTIMORE (No. 17 St. 17 WARD)
*FULL NAME Melby Hufnagel
(Residence in Baltimore: No. 408 Myrtle Ave St.; yrs. Life mos. Life ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single
(Write the words)
6-DATE OF BIRTH, Sept 1909
(Month) (Day) (Year)
7-AGE, 10 yrs. 0 mos. 0 da. If LESS than 1 day,hrs. or....min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
9-BIRTHPLACE, (State or Country), Bald Mt
PARENTS.
10-NAME OF FATHER, Joseph Zunitoff
11-BIRTHPLACE OF FATHER (State or Country), Russia
12-MAIDEN NAME OF MOTHER, G. Levinson
13-BIRTHPLACE OF MOTHER (State or Country), Russia

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 28, 1910
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Prob. skull
accidentally struck by automobile
(Duration)yrs.mos.ds.
CONTRIBUTORY (Secondary)
(Signed) W. H. H. H. (Coroner.) M. D. June 27, 1910 (Address) 1637 Carey
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph Zunitoff
(Address) 408 Myrtle Ave
15- Robert P. Harrison,
Burial Permit Clerk

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death 2 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....
19-PLACE OF BURIAL OR REMOVAL, Baltimore Schenck DATE OF BURIAL, 6-30-10
20-UNDERTAKER, Jack Lewis ADDRESS 1411 E. Pratt

D. 44377

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44377

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 24 E. Weber St.

ST.:

WARD)

2-FULL NAME

William H. Smith. (C)

(Residence in Baltimore: No.

24 E. Weber St.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

71

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male.

4-COLOR OR RACE,

Colored.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower.

6-DATE OF BIRTH,

Do not know.

(Month)

(Day)

(Year)

7-AGE,

71

Yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Do not know.

11-BIRTHPLACE OF FATHER (State or Country),

Do not know.

12-MAIDEN NAME OF MOTHER

Do not know.

13-BIRTHPLACE OF MOTHER (State or Country),

Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Ford. (C)

(Address) 26 E. Weber St.

15-

Robert P. Harrison,

Regist.

Burial Permit Clerk

17325

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 28th. 1920, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Otto M. Remhard M. D. (Coroner.)

June 28, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

JUN 29 1920

UNIVERSITY OF MARYLAND

JUN 2 1920

D. 44378 HEALTH DEPARTMENT—CITY OF BALTIMORE

D/44378

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St Paul Apts-

ST.;

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Samuel Dawson Buck

(a) RESIDENCE. NO.

St. Paul Apts-

ST.

WARD.

(Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

50 yrs. ? mos. ?

ds.

How long in U. S., if of foreign birth?

79 yrs. 3 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Alice Buck

6 DATE OF BIRTH (month, day, and year)

March 2-1841

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

79

3

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Secretary - Emeritus of

(b) General nature of industry, business, or establishment in which employed (or employer)

Credit Men's Assn

(c) Name of employer

J. Bullenmore

9 BIRTHPLACE (city or town) (State or country)

Buckton - Warren Co.

10 NAME OF FATHER

John Gill Buck

11 BIRTHPLACE OF FATHER (city or town)

Buckton,

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Eliza McKay

13 BIRTHPLACE OF MOTHER (city or town)

Adonille

(State or country)

Virginia

14

Informant

Mr. L. G. Buck - (brother)

(Address)

St. Paul Apts-

15

JUN 29 1920

19

Robert F. Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6-29 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 10, 1920, to June 29, 1920,

that I last saw him alive on June 28, 1920,

and that death occurred, on the date stated above, at 11:30 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Hypertension

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic & X-ray

(Signed) Joseph J. Hering, M. D.

19 (Address) 1812 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Green Mount Cemetery

July 1-1920

20 UNDERTAKER

STEWART & MOWEN COMPANY

(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificate.

D 44379

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44379

CERTIFICATE OF DEATH.

PLACE OF DEATH *Infirmary*
CITY OF BALTIMORE (No. *Church Home* ST.: *6* WARD) REGISTERED No. C.....
2-FULL NAME *Oliver Noonan* (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(Residence in Baltimore: No. *(Belair md)* St.; yrs., mos. *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)
6-DATE OF BIRTH *About -*, 1870
(Month) (Day) (Year)

7-AGE, *about 50* ? ? If LESS than 1 day, yrs. mos. ds. hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Refrigerator*
(b) General nature of industry, business, or establishment in which employed (or employer), *for Bel Air Md*

9-BIRTHPLACE, (State or Country), *Bel Air Md*

PARENTS.
10-NAME OF FATHER, *unknown*
11-BIRTHPLACE OF FATHER (State or Country), *unknown*
12-MAIDEN NAME OF MOTHER, *unknown*
13-BIRTHPLACE OF MOTHER (State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *W. H. Harrison*
(Address) *Bel Air Md*

15- Robert P. Harrison,
JUN 29 1920, 101
Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Jun 29*, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death at the day stated above.

18-CAUSE OF DEATH* was as follows:
Trauma: fire works exploded in pocket when he fell.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary).....
Signed *W. H. Harrison* M. D.
6-29-20 (Address) *W. H. Harrison*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death, 0 yrs. 0 mos. 2 ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?.....
Former or usual residence *Bel Air Md*

19-PLACE OF BURIAL OR REMOVAL, *Bel Air Md* DATE OF BURIAL,, 19....

20-UNDERTAKER ADDRESS
STEWART & MOWEN COMPANY 108 W. NORTH AVE.
(WILLIAM F. WOODEN, Successor)

10.44380 HEALTH DEPARTMENT—CITY OF BALTIMORE **10.44380**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 9th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John Haraldson

(a) RESIDENCE. NO.

3801 Kennedy Ave. Baltimore, Md.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. Life mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

-

6 DATE OF BIRTH (month, day, and year)

Feb 12 - 1917

7 AGE

Years

Months

Days

If LESS than 1 day,h.m. ormin.

3

4

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

Md.

10 NAME OF FATHER

Jacob Haraldson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Norway

12 MAIDEN NAME OF MOTHER

Helena Hilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Norway

14

Informant (Address)

J. H. H. Records

15

Filed

Robert P. Harrison,

Registrar

JUN 29 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 28 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 1st, 1920, to June 28, 1920,

that I last saw him alive on June 28, 1920,

and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Congenital Hydrocephalus

(duration) 3 yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 2, 1920

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Exam.

(Signed) Harold L. Higgins, M. D.

629 1920 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cem

June 30 1920

20 UNDERTAKER

ADDRESS

Wm. J. Tucker & Sons

714 Pa

TION is very important. See instructions on back of certificates.

D. 44381

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44381

CERTIFICATE OF DEATH.

157

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST.:

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. 34 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an investigation (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner.)

June 24, 1920 (Address) 1612 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly entered. See instructions on back of certificate.

JUN 9 1920

D. 44382 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital*ST.: *27*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Amos Reeder(a) RESIDENCE. NO. *Governments Rd.*

ST.,

WARD. *Phila. Pa.*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

1 mos. *7*

ds.

How long in U. S., if of foreign birth?

yrs.

1 mos. *7*

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*White*5 Single, Married *Widowed*,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Widowed Mary Reeder*

6 DATE OF BIRTH (month, day, and year)

Jun 23, 1860

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*60 yrs*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Sargent Police 061*(b) General nature of industry,
business, or establishment in
which employed (or employer)*Police*

(c) Name of employer

*Retired*9 BIRTHPLACE (city or town)
(State or country)*Delaware*

10 NAME OF FATHER

*Amos S. Reeder*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Pa.*

12 MAIDEN NAME OF MOTHER

*Lillian Jeffries*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Pa.*

14

Informant
(Address)*Mabel P. McNeely
907 Woodland Ave.*

15

Filed

JUN 29 1920

Robert P. Harrison,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 29 1920

17

I HEREBY CERTIFY, That I attended deceased from

*May 31 1920, to June 29, 1920,*that I last saw him alive on *June 29, 1920,*and that death occurred, on the date stated above, at *12:30 P. m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum(duration) yrs. *2* mos. — ds.CONTRIBUTORY
(Secondary)*Myocardial Insufficiency,*
(duration) yrs. — mos. — ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Incision & Drainage

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

W. H. Meyer

M. D.

, 19

(Address)

*University Hospital**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Philadelphia Pa.

20 UNDERTAKER

W. H. Meyer

TION is very important. See instructions on back of certificates.

Burial Permit Clerk

D.44383 HEALTH DEPARTMENT—CITY OF BALTIMORE D.44383
120✓

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5th Reg. Army ST. 11 WARD)

2-FULL NAME Mary M. McDonald

(a) RESIDENCE. NO. 5th Reg. Army WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

5 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 33 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

Single, Married, Widowed,
or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

JUN 29 1920

ROBERT E. KAUFER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-28 1920

17 I HEREBY CERTIFY, That I attended deceased from
June 28, 1920, to June 28, 1920,
that I last saw him alive on June 28, 1920,
and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Uremic Convulsion

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

6-29 1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

TION is very important. See instructions on back of certificate.

Dr. Marshall Smith 118 N. Calhoun St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 So. Ann

ST. 2nd WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JOHN MALINSKI,

(a) RESIDENCE. NO. 518 So. Ann

(Usual place of abode)

ST. 2nd- WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male, 4 COLOR OR RACE White, 5 Single, Married, Widowed, or Divorced (write the word) Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 7-1920.

7 AGE Years 0 Months 8 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md., (State or country)

10 NAME OF FATHER John Malinski,

11 BIRTHPLACE OF FATHER (city or town) Poland, (State or country)

12 MAIDEN NAME OF MOTHER Agnis Witka,

13 BIRTHPLACE OF MOTHER (city or town) Poland, (State or country)

14 Informant Mrs. Agnis Malinska, (Mother) (Address) 518 So. Ann Street

15 JUN 30 1920 BIRTHAL Permit 01974

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29- 19 20.

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1920, to June 29, 1920, that I last saw him alive on June 29, 1920, and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Amblyopia Intox

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Winkler, M. D.

129, 1920 Address 16 S. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus.

6/30- 1920

20 UNDERTAKER

ADDRESS

M. F. Sadovskii, gov. S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

1044386

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044386

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3026 Fayette St.)

WARD)

2-FULL NAME

Jesse Lang

(Residence in Baltimore: No. 3026 Fayette St.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

38 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH

Nov. 19, 1840

7-AGE

80

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Cement worker

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

George Lange

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Conrad Weber

(Address) 2026 E Fayette St.

15-

JUN 30 1920 ROBERT S. KEAUTER

Filed 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Jun. 29, 1920

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Phlebotomy

(Signed) J. K. Kusley M. D.

627... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Western Cemetery July 1, 1920

20-UNDERTAKER

ADDRESS

Louis Heermann 32 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter statement of OCCUPATION in very important. See instructions on back of certificate.

1044387 HEALTH DEPARTMENT—CITY OF BALTIMORE 64 1044387

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 Parrish

ST.: 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Galbert

(Residence in Baltimore: No. 216 Parrish St.

St.: 35 yrs., - mos. - ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

widow

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

51

yrs.

+ mos.

+ ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Domestic 70

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9-BIRTHPLACE,

(State or Country),

Maryland Hartford

10-NAME OF FATHER,

Charlotte Garrett

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Francis Gross

(Address)

1428 Wilmer Alley

15-

JUN 30 1920

ROBERT E. KRAUTH

Filed

191

Burial Form Reg. 11-1-18

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 28, 1920.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 27, 1920, to June 28, 1920.

that I saw her alive on June 28, 1920.

and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Chorea

(Duration) + yrs. + mos. 2 ds.

CONTRIBUTORY (Secondary)

Arterio Sclerosis

(Duration) + yrs. + mos. ds.

(Signed)

Charles E. Clark, M.D.

June 29, 1920 (Address) 1306 N. E. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Auburn Cem.

June 30, 1920.

20-UNDERTAKER

ADDRESS

A. Jones

207 S. Street

important. See instructions on back of certificate.

1044388

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044388

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 718 W. Hamburg

ST. 21 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William Hill

(Residence in Baltimore: No. 718 W. Hamburg

St. 21 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widowed

6-DATE OF BIRTH,

Mar 4, 1849

(Month) (Day) (Year)

7-AGE,

71 yrs. 3 mos. 23 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Labourer in Room factory

9-BIRTHPLACE, (State or Country),

Baltimore Md.

PARENTS.

10-NAME OF FATHER,

Mark J. Hill

11-BIRTHPLACE OF FATHER (State or Country),

England

12-MAIDEN NAME OF MOTHER

Hannah

13-BIRTHPLACE OF MOTHER (State or Country),

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Charlotte Carson

(Address) 718 W. Hamburg St.

15-

Filed

191

ROBERT B. KRAUTER

Burial Permit

JUN 30 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 27, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from June 5, 1920, to June 27, 1920, that I saw him alive on June 27, 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

old age & bronchitis from influenza

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) 5 mos. 2 ds.

(Signed) H. E. Kimpf M. D.

June 28, 1920 (Address) 1002 W. Lamar St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cemetery

DATE OF BURIAL,

June 30 1920

20-UNDERTAKER

James Dignan & Son

ADDRESS

1002 W. Lamar St.

Important. See instructions on back of certificate.

1044389

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044389

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1005 W 36

ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thruston W Bryant

a) RESIDENCE. NO.

1005 W 36

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

15

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 24 1920

7 AGE

Years

Month

Days

If LESS than 1 day, hrs. or min.

✓

✓

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

L B Bryant

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Clara R Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

md

14

Informant (Address)

L B Bryant 1005 W 36 St

JUN 30 1920

ROBERT E KRAUSE, Jr.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 29 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 28, 1920, to June 30, 1920,

that I last saw him alive on June 30, 1920,

and that death occurred, on the date stated above, at 9:20 P. M.

The CAUSE OF DEATH* was as follows:

convulsions

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Hot weather (overheating)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. R. W. M. D.

6/30/20 (Address) 865 W 36 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Marys Hospital June 30 20

20 UNDERTAKER

ADDRESS

Chenoweth Son Chestnut St

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044390

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1342 Mosher

ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Enrique Mackall

(a) RESIDENCE. NO. 1342 Mosher

ST.

WARD.

(If nonresident give city or town and State)

(Usual place of abode)
Length of residence in city or town where death occurred 10 yrs. — mos. — ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

M

W

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

JUN 30 1920

ROBERT E. KLEIN

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

May 28, 1920, to June 27, 1920,
that I last saw him alive on June 27, 1920,
and that death occurred, on the date stated above, at 1300 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the

CONTRIBUTORY
(Secondary)

(duration)

yrs.

1 mos.

4 ds.

18 Where was disease contracted
if not at place of death?

1342 Mosher St.

Did an operation precede death?

NO

Date of

Was there an autopsy?

8

What test confirmed diagnosis?

Characteristic of

(Signed)

C. H. Fowler

M. D.

Address

712 S. Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn

June 30 1920

20 UNDERTAKER

Sam'l H. Chase

ADDRESS

1342 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Special Permit to

1044391

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1044391

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1833 Asquith

ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Susan Virginia Alderson

(a) RESIDENCE. No.

1833 Asquith

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

August 22 1862

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

57

10

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Harford Co Md

10 NAME OF FATHER

James B. Alderson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Harford Co Md

12 MAIDEN NAME OF MOTHER

Susan R. Vansant

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Harford Co Md

14

Informant (Address)

Mrs Laura A Standiford 1833 Asquith St

15

Filed

JUN 30 1920

ROBERT B. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 29 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 14, 1920, to June 29, 1920,

that I last saw him alive on June 28, 1920,

and that death occurred, on the date stated above, at 5:40 a.m.

The CAUSE OF DEATH* was as follows:

Septicemia (origin unknown)

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood examination

(Signed) Wm J. Watson, M. D.

, 19 (Address) 2128 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cemetery

July 1st 1920

20 UNDERTAKER

ADDRESS

George Schilling & Sons

1126 E. Monument St

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044392

1044392

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 Greenwillow

ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Martha Thompson

(a) RESIDENCE. No. 526 Greenwillow

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 6 mos. 21 ds. How long in U. S., if of foreign birth? 3 yrs. 6 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female Colored

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Dec 5 1870

6 DATE OF BIRTH (month, day, and year)

Dec 5 1870

7 AGE

Years

Months

Days

If LESS than

1 day. hrs.

or min.

30

30

6

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Elihu Thompson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Easter Shore, Md

12 MAIDEN NAME OF MOTHER

Martha Thompson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md

14

Informant (Address)

Rachel Greene 526 Greenwillow St

15

JUN 30 1920

ROBERT B. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 26 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 10th, 1920, to June 26th, 1920,

that I last saw her alive on June 26th, 1920,

and that death occurred, on the date stated above, at 7:45 P. M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia (?) because Patient had a neoplasm removed from Back last winter; and the

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary)

Pleurisy

(duration) yrs. mos. 16 ds.

18 Where was disease contracted

if not at place of death?

526 Greenwillow

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

L. B. Evans M. D.

19 (Address)

Greene & Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel Hill

June 30 1920

20 UNDERTAKER

Samuel S. S. S.

ADDRESS

578 N. B. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

1044393 · HEALTH DEPARTMENT—CITY OF BALTIMORE 1044393

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 923 W. Saratoga St. 18

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Death Johnson

(Residence in Baltimore: No. 923 W. Saratoga St.

St. yrs., 6 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single

6-DATE OF BIRTH, Dec 24, 1918 (Month) (Day) (Year)

7-AGE, 1 yrs. 6 mos. 5 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, none (b) General nature of industry, business, or establishment in which employed (or employer), none

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER, Bald City Sherman Johnson 11-BIRTHPLACE OF FATHER, (State or Country), Md 12-MAIDEN NAME OF MOTHER, Helen Johnson 13-BIRTHPLACE OF MOTHER, Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Johnson

(Address) 923 W. Saratoga St.

15-ROBERT A. BRAUER Registrar.

Filed JUN 30 1920

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 29, 1920 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally shot while on duty at Port of Security Building of Mercury. (Duration) yrs. mos. 11 ds.

CONTRIBUTORY Acc. dent (Secondary)

(Duration) yrs. mos. 11 ds.

(Signed) H. K. G. M. D. (Coroner.)

61.29. 1920 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Anthony June 30, 1920

20-UNDERTAKER ADDRESS 114 W.

Brown & Ireland Scholastic

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

44394

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044394

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

313 N. Poppleton

ST.: 18 WARD)

2-FULL NAME

Bertha Mason-Strickland

(a) RESIDENCE. No.

313 N Poppleton

ST.: 17th WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

34

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Col.

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Virgie Strickland

6 DATE OF BIRTH (month, day, and year)

1886

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

34

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic 03

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

Md

10 NAME OF FATHER

John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14 Informant (Address)

Levin H. Mason
702 W. Mulberry St

15 Filed

JUN 3 0 1920

ROBERT E. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6/27/1920

17

I HEREBY CERTIFY, That I attended deceased from

June 1st, 1920 to June 27th, 1920,
that I last saw ^{her} alive on June 26th, 1920.

and that death occurred, on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach?

Unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

none

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical

(Signed)

G. Bowley M. D.

6/28/20 (Address)

908 88th St &

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel Green

Jun 30 1920

20 UNDERTAKER

Dane Carter

ADDRESS

916
Ct me

TION is very important. See instructions on back of certificates.

1044395 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 George

ST. 17

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 605 George

St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

July 23, 1907

7-AGE,

12 yrs. 11 mos. 3 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Schoolgirl.

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Chas. Boston

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore, Md.

12-MAIDEN NAME OF MOTHER

Elie Garner

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Chas. Boston
427 St. Mary's

15-

Filed

JUN 30 1920

ROBERT B. BAUTER

BALTIMORE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 26, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 21, 1920, to June 26, 1920,

that I saw her alive on June 26, 1920,

and that death occurred, on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis, & Pharyngitis
primarily

(Duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) William E. Boston M. D.

June 27, 1920 (Address) 762 Duquesne

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt. Auburn Cem.

June 28, 1920

20-UNDERTAKER

ADDRESS

Samuel Jewell

318 N. E. St.

important. See instructions on back of certificate.

1044396

HEALTH DEPARTMENT—CITY OF BALTIMORE

1144396

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Mercy Hospital

ST.: 15

WARD)

2-FULL NAME

~~John~~ Martin Schmitt

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

1405 Lounar St

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

29 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

29 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

his name Schmitt

6 DATE OF BIRTH (month, day, and year)

Don't know

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Germany

10 NAME OF FATHER

Harry Schmitt

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Christina Mustat

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

German

14

Informant
(Address)Minnie Schmitt
1405 Lounar St

15

JUN 30 1920

ROBERT B. KRAUTER

Burial Per

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 29 - 1920

17

I HEREBY CERTIFY, That I attended deceased from

Jan 25, 1920, to June 29, 1920,

that I last saw him alive on

June 29, 1920

and that death occurred, on the date stated above, at

3 m.

The CAUSE OF DEATH* was as follows:

Cerebral H embolose
Pneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Don't know

Did an operation precede death?

No Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Autopsy
G. W. Harbottle

(Signed)

M. D.

19 (Address)

Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn

July 3 - 1920

20 UNDERTAKER

Wm. Cook

ADDRESS

502 E. North Ave

TION is very important. See instructions on back of certificates.

1044397 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044397

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *605 S. Green* ST. *22* WARD)
 REGISTERED NO. _____
 (If death occurred in
 a hospital or institu-
 tion, give its NAME
 instead of street and
 number.)
2-FULL NAME *Mary J. Walch*(a) RESIDENCE. NO. *605 S. Green* ST. _____ WARD. _____
 (Usual place of abode) (If nonresident give city or town and State)Length of residence in city or town where death occurred *65* yrs. *2* mos. *1* ds. How long in U. S., if of foreign birth? *65* yrs. *2* mos. *1* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX _____ 4 COLOR OR RACE *White* 5 ~~Single, Married, Widowed,~~
~~or Divorced, (write the word)~~ *Widow*

5a If married, widowed, or divorced

HUSBAND of *Andrew Walch*
 (or) WIFE of6 DATE OF BIRTH (month, day, and year) *Oct 13-1886*7 AGE Years *83* Months *8* Days *13* If LESS than
 1 day. _____ hrs. _____
 or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
 particular kind of work *None*(b) General nature of industry,
 business, or establishment in
 which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
 (State or country) *Germany*10 NAME OF FATHER *Henry Drexler*11 BIRTHPLACE OF FATHER (city or town)
 (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Mary R. Reiff*13 BIRTHPLACE OF MOTHER (city or town)
 (State or country) *Germany*14 Informant *Ratie Walch*
 (Address) *605 S. Green*15 Filed *JUN 30 1920* *ROBERT E. KAUFER*
 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 28* 19*20*17 HEREBY CERTIFY, That I attended deceased from
June 15, 19*20*, to *June 28*, 19*20*,
 that I last saw him alive on *June 28*, 19*20*,
 and that death occurred, on the date stated above, at *5:10* p. m.The CAUSE OF DEATH* was as follows:
acute Bronchitis

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
 (Secondary)(duration) _____ yrs. *13* mos. _____ ds.18 Where was disease contracted
 if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) *Stacy Boyd*, M. D.19 Address *602 Columbia**State the Disease Causing Death, or in deaths from Violent Causes,
 state (1) Means and Nature of Injury, and (2) whether Accidental,
 Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Western Cemetery**July 1* 19*20*

20 UNDERTAKER

ADDRESS

*Jos. Frederickson Son**2175 Penn*

TION is very important. See instructions on back of certificates.

D 443 98

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1202 D 443 98

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1931 Mosher

ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Lautenberger

(a) RESIDENCE. No. 1931 Mosher

(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Lautenberger

6 DATE OF BIRTH (month, day, and year) Aug 6 - 1846

7 AGE Years 73 Months 10 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Henry Brule

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Catharine Lautenberger 136 Speedway

15 Filed JUN 30 1920 ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1920

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1920, to June 29, 1920, that I last saw her alive on June 29, 1920, and that death occurred, on the date stated above, at 1:30 a.m. The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Immunological etc (Signed) J. Thomas Nelson, M. D.

19 (Address) 1001 E. Fulton - Ann

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Green Mount Cemetery July 1st 1920

20 UNDERTAKER ADDRESS

H. B. Kappert 2136 Fulton Ave

TION is very important. See instructions on back of certificates.

44399

HEALTH DEPARTMENT—CITY OF BALTIMORE

642 44399

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2626 St. Benedict ST.: 70 WARD)

2-FULL NAME Margaret Strube

(a) RESIDENCE. No. 2626 St. Benedict ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. - mos. 26 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced (or) WIFE of

HUSBAND of John S. Strube

6 DATE OF BIRTH (month, day, and year)

June 2-1852

7 AGE

68

Months

—

Days

26

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md

10 NAME OF FATHER

Louis Neel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Elizabeth Schaeffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Miss Mary Strube 2626 St. Benedict

15

ROBERT B. KRAUTER

Registrar

Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-28-1920

17

I HEREBY CERTIFY, That I attended deceased from Mch 25, 1919, to June 28, 1920.

that I last saw him alive on " " " " 1920.

and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH* was as follows:

Left sided Hemiplegia

about 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

Bronchial Asthma (duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

No

Did an operation precede death?

No

Was there an autopsy?

What test confirmed diagnosis?

Char. C. Conser, M. D.

(Signed)

6/29/20 (Address) 1101 N. Fullin Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Criminal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

St. Mary's Cemetery July 19, 1920

tion is very important. See instructions on back of certificates.

JUN 30 1920

Paul & Co. Clayland
 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *111 S. Calhoun* ST.; *19* WARD)

2-FULL NAME

(Residence in Baltimore: No. *111 S. Calhoun* St.; *18* yrs., *7* mos., *5* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

Nov 23, 1920
(Month) (Day) (Year)

7-AGE,

18 yrs., 7 mos., 5 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *none*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Balto Md.

PARENTS.

10-NAME OF FATHER,

Joseph Dressman

11-BIRTHPLACE OF FATHER (State or Country),

Balto Md.

12-MAIDEN NAME OF MOTHER

Mabel Clayland

13-BIRTHPLACE OF MOTHER (State or Country),

Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Mabel Clayland*(Address) *111 S. Calhoun St.*

15-

JUN 30 1920

ROBERT B. KAUTER

191 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 28, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *May 22, 1920*, to *June 28, 1920*, that I saw him alive on *May 27, 1920*, and that death occurred, on the date stated above, at *39* m.

The CAUSE OF DEATH* was as follows:

general tuberculosis
about 3
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *H. E. Knapp* M. D.
June 29, 1920 (Address) *1602 W. Laverne*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Cedar Hill Cem

DATE OF BURIAL,

June 30, 1920

20-UNDERTAKER

Joseph B. Cook

ADDRESS

1003 N. Balto Street

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very
important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1044401

151 10444

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 663 N Saratoga ST. 4 WARD)

REGISTERED NO. C—

(If death occurred in hospital or in home, give its NAME of street and number, fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 663 N Saratoga St.; 1 yrs., 1 mos.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

May 20th, 1920
(Month) (Day) (Year)

7-AGE,

40 yrs., 40 mos., 40 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Baltimore Md

10-NAME OF FATHER,

Sam Serio

11-BIRTHPLACE OF FATHER (State or Country),

Italy

12-MAIDEN NAME OF MOTHER

Sarah Serio

13-BIRTHPLACE OF MOTHER (State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam Serio
(Address) 663 N Saratoga

15-

JUN 30 1920 BOBBY E KRAUTER
Filed 101 BURIAL PERMIT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 30,
(Month) (Day)

17- I HEREBY CERTIFY, That I attended deceased

June 29 1920, to June 30
that I saw him alive on June 29
and that death occurred, on the date stated above, at
The CAUSE OF DEATH* was as follows:

7 1/2 Months (Cholera)
(Duration) ... yrs. ... mos.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos.
(Signed) Frank W. Munson
June 30 1920 (Address) 322 N. York

*State the DISEASE CAUSING DEATH, or, in deaths from Violence, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

20-UNDERTAKER

John J. Lacey, Prop 1314

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1044402

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10449
38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital.*

ST.: *70* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give it instead of registered number.)

2-FULL NAME

Sadie Scott.

(a) RESIDENCE. NO.

42 Ellamont

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and state)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

(or) WIFE of

James Scott

6 DATE OF BIRTH (month, day, and year)

February

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

39

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

J. M. C. Frelhinger

9 BIRTHPLACE (city or town)

(State or country)

md.

10 NAME OF FATHER

Wm Thomas

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

md

12 MAIDEN NAME OF MOTHER

Truman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

md

14

Informant

(Address)

Daniel Scott

904 Prince St

15

Filed

JUN 30 1920

ROBERT R. KRAUTER

Registrar

Barial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 29

17

I HEREBY CERTIFY, That I attended death

June 18

1920

to June 29

that I last saw him alive on *June 29*

and that death occurred, on the date stated above, at *4*

The CAUSE OF DEATH* was as follows:

Bilateral Salpingo oophorectomy + myoma of uterus

(duration)

yrs.

CONTRIBUTORY (Secondary)

Poor op. shortly

(duration)

yrs.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

yes Date of *6-28*

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

J. Mason Kendall

, 19 (Address)

University Hosp

*State the Disease Causing Death, or in Deaths from Violence state (1) Means and Nature of Injury, and (2) whether Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE

mt arthur cemetery

20 UNDERTAKER

Edward H. Pyle

ADDRESS

904 Prince St

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

10-44403.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 N. ~~W. 11th~~ ST.: 6 WARD)

2-FULL NAME

(a) RESIDENCE. No. 411 N. ~~W. 11th~~ ST.: 6 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos.

ds.

How long in U. S., if of foreign birth Life mos.

REGISTERED NO. 10444

(If death occurred in a hospital or institution, give it instead of registered number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female white

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1902

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

17

6

—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Housewife

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

JUN 30 1920

ROBERT F. LEAHY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30

17

I HEREBY CERTIFY, That I attended on May 9, 1920, to June 30

that I last saw her alive on June 29

and that death occurred, on the date stated above, at 8

The CAUSE OF DEATH* was as follows:

Chronic heart disease (Bacterial Streptococcus viridans)

(duration) yrs. ?

CONTRIBUTORY (Secondary)

(duration) yrs. 9

18 Where was disease contracted if not at place of death? 600 W. 11th St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Cult

(Signed) Frank A. Smith

30 1920 (Address) 1126 Calverton

*State the Disease Causing Death, or in deaths from state (1) Means and Nature of Injury, and (2) whether Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

Julius Lewis

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Form 6-9-19 H. P. Co. 1000 Hks.

D. 44404 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 444

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 E Fayette St. ST. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its name instead of street number.)

2-FULL NAME Rebecca Kaplan

(a) RESIDENCE. NO. 1806 E Fayette ST. WARD.

(Usual place of abode)

(If nonresident give city or town and state)

Length of residence in city or town where death occurred 13 yrs. - mos. - ds. How long in U. S., if of foreign birth? 13 yrs. - mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE Years 76 Months - Days - If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Mary Richmond (Address) 1806 E Fayette St.

15 Robert P. Harrison, Registrar

JUN 30 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26

17 I HEREBY CERTIFY, That I attended deceased June 26, 1920, to June 28, that I last saw him alive on June 28

and that death occurred, on the date stated above, at 6

The CAUSE OF DEATH* was as follows: Broncho-pneumonia

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and

(Signed) Dr. L. M. Miller

, 19 (Address) 6 N. May

*State the Disease Causing Death, or in deaths from Violence state (1) Means and Nature of Injury, and (2) whether Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE

Hebrew-Blair Rd. Cemetery June

20 UNDERTAKER ADDR

Max Linnson Bal

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. It should be stated EXACTLY. PHYSICIAN should state item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.44405 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its name instead of street number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1336 St. Luzerne ST.: 8

WARD)

2-FULL NAME William H. Grooms

(a) RESIDENCE. No. 1336 St. Luzerne ST.,

WARD. Baltor. Co. 8

(Usual place of abode) Length of residence in city or town where death occurred 2 Months mos. ds. How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18-1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29

17 I HEREBY CERTIFY, That I attended deceased

May 22, 1920, to June 29

that I last saw him alive on June 28

and that death occurred, on the date stated above, at 72

The CAUSE OF DEATH* was as follows:

Bright's Disease

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violence, state (1) Means and Nature of Injury, and (2) whether Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE

20 UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIAN SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Rohrbach
D.44407 HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1307 N. Baltimore* ST.: *19* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *1307 N. Balto* ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred *45* yrs. *5* mos. *12* ds. How long in U. S., if of foreign birth *Life* yrs. mos.

REGISTERED NO.

(If death occurred in a hospital or institution, give its number instead of street number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *Wh* 5 Single, Married, Widowed, or Divorced (write the word) *married*

5a If married, widowed, or divorced
HUSBAND of *Charlotte Rohrbach*
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1/17/72*

7 AGE Years *48* Months *5* Days *12* If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Restaurant keeper*
(b) General nature of industry, business, or establishment in which employed (or employer) *Restaurant*
(c) Name of employer

9 BIRTHPLACE (city or town) *And*
(State or country)

10 NAME OF FATHER *John Rohrbach*

11 BIRTHPLACE OF FATHER (city or town) *Germany*
(State or country)

12 MAIDEN NAME OF MOTHER *Heiter*

13 BIRTHPLACE OF MOTHER (city or town) *Germany*
(State or country)

14 Informant *Charlotte Rohrbach*
(Address) *1307 N. Balto. St.*

15 Filed *Robert P. Harrison,*
Registrar

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 28*

17 I HEREBY CERTIFY, That I attended deceased *June 28*, 19 *20*, to *June 29*

that I last saw him alive on *June 28*

and that death occurred, on the date stated above, at *1*

The CAUSE OF DEATH* was as follows:

Laryngeal Tubercle

(duration) *10* yrs.

CONTRIBUTORY
(Secondary)

(duration) ____ yrs. ____ mo.

18 Where was disease contracted

If not at place of death? *no*

Did an operation precede death? *no* Date of ____

Was there an autopsy? *no*

What test confirmed diagnosis? *Exam of*

(Signed) *Dr. J. L. Duane*

Appt. 1520 (Address) *721 N. Eutaw St.*

*State the Disease Causing Death, or in deaths from Violence (1) Means and Nature of Injury, and (2) whether Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park

20 UNDERTAKER

C. W. Dill

DATE

July

ADDRESS

Fred

D.44408

HEALTH DEPARTMENT—CITY OF BALTIMORE

10,44408

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 926 Ashland ave ST.; 10 WARD)
2-FULL NAME Santo Ballistreri
(Residence in Baltimore: No. 926 Ashland ave St.; 15 yrs., 1 mos., 15 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male
4-COLOR OR RACE. White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married
(Write the word.)
6-DATE OF BIRTH, June 30, 1881
(Month) (Day) (Year)
7-AGE, 38 yrs., 11 mos., 28 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer). Self

9-BIRTHPLACE,
(State or Country), Italy

PARENTS.
10-NAME OF FATHER, Carmelo Ballistreri
11-BIRTHPLACE OF FATHER (State or Country), Italy
12-MAIDEN NAME OF MOTHER, Marianna Locantore
13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pietro Borghese
(Address) 322 - East 1st

15-

1920 0 1920 191 Robert P. Harrison
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 28, 1920.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 2 1919, to June 28 1920,
that I saw him alive on June 28 1920,
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 11 yrs., 1 mos., 1 ds.

CONTRIBUTORY Phthisis
(Secondary)

(Duration) 1 yrs., 1 mos., 1 ds.

(Signed) Wm. L. Ballistreri M. D.

June 30, 1920 (Address) 1038 P. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs., 1 mos., 1 ds. In the State 1 yrs., 1 mos., 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeeming Cem DATE OF BURIAL, July 1, 1920.

20-UNDERTAKER, George J. Ruth ADDRESS 1735 - Harbor

D. 44409

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44409

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 Webster

ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward A. Re Minnis

(a) RESIDENCE. NO. 1410 Webster

(Usual place of abode)

ST.: WARD.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs. 5

mos. 22

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan. 8. 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

John H. Re Minnis

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Co. Md.

12 MAIDEN NAME OF MOTHER

Annie E. Penzy

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

John H. Re Minnis 1410 Webster St

15

Filed

19

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 30, 1920

17

I HEREBY CERTIFY, that I attended deceased from

June 15, 1920, to

June 30, 1920,

that I last saw him alive on

June 29, 1920

and that death occurred, on the date stated above, at

6 am

The CAUSE OF DEATH* was as follows:

Gastro Enteritis
Ulcerative stomatitis
Acute Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Physical Examination

(Signed)

J. Edward Norris, M. D.

6/30/1920 Address

1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Augustine Cem. Elbridge Md.

July 1 1920

20 UNDERTAKER

M. G. Flynn

ADDRESS

1422 Light St

CAUSE OF DEATH is printed in plain terms. See instructions on back of certificates.

JUN 30 1920

D. 44410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44410

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1600 Webster

ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Fannie Brew

(a) RESIDENCE. NO.

1600 Webster

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

45 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

45 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, divorced

(or) With of

Arthur Brew

6 DATE OF BIRTH (month, day, and year)

Oct. 10, 1879

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

70

8

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Wales,

10 NAME OF FATHER

William Sellar

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Wales!

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Don't know

14

Informant (Address)

Albert Hurwall
204 E. 31st St.

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6/29

1920

17

I HEREBY CERTIFY, That I attended deceased from

June 10, 1920, to June 29, 1920

that I last saw him alive on June 28, 1920.

and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Infermities of age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. E. Duval M. D.

19 Address 910 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cem.

July 2, 1920

20 UNDERTAKER

ADDRESS

M. J. Flynn

1423 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

UN 30 1920

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *59 Falls Road*ST.: *13* WARD)2-FULL NAME *Mary A King*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. *59 Falls Road*

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

1 yrs.

mos.

9 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

M

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 21 1918*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1**9*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *M.D.*10 NAME OF FATHER *Phillip King*11 BIRTHPLACE OF FATHER (city or town) (State or country) *M.D.*12 MAIDEN NAME OF MOTHER *Mary Sims*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *M.D.*

14

Informant (Address) *Phillip King*

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 30 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*June 30, 1920, to June 30, 1920.*that I last saw him alive on *June 30 1920*and that death occurred, on the date stated above, at *3:10 P.M.*

The CAUSE OF DEATH* was as follows:

Pneumonia(duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *A. J. Davis*

M. D.

430 1920 (Address) *800 33rd St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mary's Hospital July 2 1920

20 UNDERTAKER

ADDRESS

Chenoweth & Son Chestnut

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: yrs., mos. 1/4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mark S. Miller

(Address) 301 W-29

15-

Robert P. Harrison,

16-

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

June 28 1920, to June 30 1920,

that I saw her alive on June 30 1920,

and that death occurred, on the date stated above, at 3.30 PM

The CAUSE OF DEATH* was as follows:

Marasmus

Coarctation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Roscoe Brown M. D.

(Address) June 30, 1920, 2435 Maryland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER,

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST. *7* WARD)REGISTERED No. C *151*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Baby Waechter*(Residence in Baltimore: No. *Hebrew Hospital* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *W*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*6-DATE OF BIRTH, *June 30, 1920*

(Month)

(Day)

(Year)

7-AGE, *4 yrs., 8 mos., 4 ds.*

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.....
- (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *MD -*

PARENTS.

10-NAME OF FATHER, *Samuel H Waechter*11-BIRTHPLACE OF FATHER (State or Country), *Poland*12-MAIDEN NAME OF MOTHER *Rebecca Schoen*13-BIRTHPLACE OF MOTHER (State or Country), *Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Lewis*(Address) *9411 E. Balt.*

15-

Robert P. Harrison,

Filed, 191.....

JUN 30 1920

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 30, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 30, 1920*, to *June 30, 1920*,that I saw her alive on *June 30, 1920*,and that death occurred, on the date stated above, at *6:40* m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) *Prematurity*

(Duration).....yrs.....mos.....ds.

(Signed) *Harry Wedemann* M. D.6/30, 1920 (Address) *Hebrew Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Markman Circle Mt. Carmel*DATE OF BURIAL, *7-1-1920*20-UNDERTAKER *Jack Lewis*ADDRESS *9411 E. Balt.*

STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.
10.44414

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.44414

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hehran aged same* ST.; *5* WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Yetta Leharitch*

(a) RESIDENCE. NO. *115 Aisquith St.* ST., *New York N.Y.* WARD. *85*
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*
5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Morris Leharitch*
6 DATE OF BIRTH (month, day, and year) *Unknown 1878*
7 AGE Years *92* Months *-* Days *-* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work *Hausmash*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Hungarian*

10 NAME OF FATHER *Unknown*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Hungarian*

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Hungarian*

14 Informant (Address) *Leurs 1412 Balto St*

15 *Robert P. Harrison,* Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 30 1920*
17 I HEREBY CERTIFY, that I attended deceased from *June 25 1920* to *June 30 1920*, that I last saw *her* alive on *June 30 1920*, and that death occurred, on the date stated above, at *1 P* m.
The CAUSE OF DEATH* was as follows:

Myocarditis
Old age
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *no*
Did an operation precede death? *no* Date of _____
Was there an autopsy? *no*
What test confirmed diagnosis? *Clinical*
(Signed) *W. J. Raykin* M. D.
6/30/20 Address) *210 Aisquith*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *New York* DATE OF BURIAL *5/1/21*

20 UNDERTAKER *Jack Lewis* ADDRESS *1411 Balto*

UN 301920

D. 44415 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Home of the aged*)ST.: *70* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *George Springle*(a) RESIDENCE. NO. *Fulton and Franklin*

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. ds. How long in U. S., if of foreign birth? *10* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*—*6 DATE OF BIRTH (month, day, and year) *1841*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*79**—**—*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

—

(c) Name of employer

—

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Geo. M. Springle

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

*Sup't. Home of the aged
Fulton and Franklin*

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 29 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*May 1 1920 to June 29 1920*that I last saw him alive on *June 29 1920*and that death occurred, on the date stated above, at *11:45 P.* m.

The CAUSE OF DEATH* was as follows:

*Congestive failure of kidneys
due to age.*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Senile myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

Clinical observation

(Signed)

W. H. C. M. D.

1930 (Address)

7202 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery July 1 1920

20 UNDERTAKER

ADDRESS

*Geo. J. Smith**Raymond*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

IN 3 0 1920

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Reich(a) RESIDENCE. No. 1522W Pratt St.

(Usual place of abode)

ST. 19 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
54				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town)
(State or country) Maryland10 NAME OF FATHER John Reich11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany14 Informant Hospital Records
(Address) M.T.H.15 Filed Robert P. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30, 1920

17 I HEREBY CERTIFY, That I attended deceased from
Nov. 12, 1918, to June 30, 1920
that I last saw him alive on June 29, 1920
and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) 5 yrs. 10 mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis T.B. in sputum(Signed) Larry R. Wilkerson M. D.
5-30-20, 19 Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery July 2, 1920

20 UNDERTAKER

Geo. Smith ADDRESS 1000
W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

UN 30 1920

10.44417

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.44417

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 S. Spring ST. 3 WARD)

REGISTERED NO. C.....

2-FULL NAME

(Residence in Baltimore: No. 26 S. Spring St.; yrs., mos., da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, Colored 5-STATUS, Widowed
(Write the word.)6-DATE OF BIRTH, May 22, 1884
(Month) (Day) (Year)7-AGE, 38 yrs., 1 mos., 7 da. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housewife
(b) General nature of industry, business, or establishment in which employed (or employer), 10709-BIRTHPLACE, (State or Country), Baltimore, Md.10-NAME OF FATHER, John Mack11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.12-MAIDEN NAME OF MOTHER, Eliza Tander13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Sarah Robinson(Address) 1425 Bonny Lane

JUL 1-1920 ROBERT E. FRAUTER

Filed..... 101. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 29, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 22 1920, to June 29 1920, that I saw her alive on June 28 1920, and that death occurred, on the date stated above, at 1 A. m.The CAUSE OF DEATH* was as follows:
Acute Parenchymatous
nephritis
(Duration)..... yrs. 2 mos. da.CONTRIBUTORY..... Low blood pressure
(Secondary) (Duration)..... yrs. 6 mos. da.(Signed) Richard S. Galt M. D.
June 29, 1920 (Address) 1514 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. da. In the State..... yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt. Auburn Cem. July 1, 192020-UNDERTAKER, ADDRESS 1723Mrs R. A. Elliott Ashland

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1000 Eastern Ave ST.: 3 WARD)

2-FULL NAME

William Frank

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

330 S. Broadway ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofKatharine Frank

6 DATE OF BIRTH (month, day, and year)

July 9th 1862

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.571119

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

Grocery

(c) Name of employer

John Kemp9 BIRTHPLACE (city or town)
(State or country)Balto
Maryland

10 NAME OF FATHER

John Frank

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Katharine Pabst

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

(Address)

Katharine Frank
230 S. Broadway

15

Filed

JUL 1 - 1920

ROBERT E. FRANKLIN

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 18 1920

17

HEREBY CERTIFY, That I attended deceased from

June 27, 1920, to June 28, 1920,
that I last saw him alive on June 27, 1920,
and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

June 27, 1920 AddressJ.H. Gershon, M. D.3100 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore CemeteryJuly 1 1920

20 UNDERTAKER

H. Sander Sons

ADDRESS

1710 Paul St

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

1044419

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1044419

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 S Ann

ST.: V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Grat

(a) RESIDENCE. NO. 403 S Ann

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Grat

6 DATE OF BIRTH (month, day, and year) Dec 25 1866

7 AGE Years 53 Months 6 Days 5 If LESS than 1 day—Hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland (State or country)

10 NAME OF FATHER Paul w lodarski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Katherine Zgalata

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Joseph Grat (Address) 403 S Ann St

15 JUL 1-1920

ROBERT F. LEAUTE Registrar Burial Permit Closed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/30/20

17 I HEREBY CERTIFY, That I attended deceased from June 26 1920, to June 29 1920, that I last saw him alive on June 29 1920, and that death occurred, on the date stated above, at 4 A.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. C. Blakes, M. D.

19 Address 14376 Bm

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary Cemetery July 2 1920

20 UNDERTAKER

ADDRESS

John M. Weber 1803 Bank St

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

New City Hospital

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles H. Ely

(a) RESIDENCE.

2510 Wolfe St. nr. Gough

No.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Funeral

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Chas. Ely

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Hoffman Co.

12 MAIDEN NAME OF MOTHER

Catherine Burrock

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Bay View Hospital

15

JUL 1 - 1920

ROBERT E. KRAUTER

Registrar

Burial Permit 01018

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 29 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 9, 1920, to June 29, 1920,

that I last saw him alive on June 28, 1920,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Fracture left femur

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) -

Terminal Bronchopneumonia

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Bay View Hospital

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Physical exam.

(Signed)

Frank T. Barber, M. D.

, 19

(Address) Bay View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

July 1 - 1920

20 UNDERTAKER

J. Hervey & Co

ADDRESS

208 William

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44421

CERTIFICATE OF DEATH,

1-PLACE OF DEATH

Union Protestant Infirmary

REGISTERED NO. C

CITY OF BALTIMORE: (No.

1514 Division

ST.: 14 WARD)

2-FULL NAME

Mrs. Freda Newman

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

U. P. 9

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

married

6-DATE OF BIRTH,

April 30, 1884

(Month)

(Day)

(Year)

7-AGE,

66 yrs., 2 mos., 1 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

none

(b) General nature of industry, business, or establishment in which employed (or employer).

037

9-BIRTHPLACE,

(State or Country),

Germany

10-NAME OF FATHER,

Max Straus

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Lillian Adler

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Hospital Records

(Address)

15-

Filed

JUL 1-1920

191

ROBERT H. KAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 1st, 1920.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 22nd 1920, to July 1st 1920.that I saw her alive on July 1st 1920.and that death occurred, on the date stated above, at 7⁴⁰ A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

General Cachexia

(Duration) 2 yrs., mos., ds.

CONTRIBUTORY (Secondary)

Gastric hemorrhage

12 hours

(Duration) yrs., mos., ds.

(Signed)

J. M. T. M. D. July 1st, 1920. (Address) Union Protestant Infirmary

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

At home

Former or usual residence

Charlottesville, Va.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Charlottesville Va. July 1st, 1920.

20-UNDERTAKER

ADDRESS

Hurt & Graham 1114 4th St. S.W.

important. See instructions on back of certificate.

1044422

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044422

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 N Calhoun ST.; 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 911 N Calhoun St.; 30 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

M

4-COLOR OR RACE,

C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH,

Unknown

(Month) (Day) (Year)

7-AGE,

54

yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)Laborer

9-BIRTHPLACE, (State or Country),

M.C.

PARENTS.

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER (State or Country),

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER (State or Country),

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Georgia Glass

(Address)

911 N. Calhoun St.

15-

Filed

191

ROBERT E. KRAUTH

Registrar.

JUL 1 - 1920

BUTLER PRINT CO.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 29, 1920, to June 30, 1920,
that I saw him alive on June 29, 1920,and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular Disease(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. S. M. Card M. D.
6/30, 1920 (Address) 2005 W. Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

At AuburnJuly 2nd, 1920

20-UNDERTAKER

ADDRESS

Sam. W. Chase - son1400 N. Harbor

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-44423

15124423

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

6-28, 1920, to 6-30, 1920

that I last saw him alive on 6-30, 1920

and that death occurred, on the date stated above, at 2:10 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Dudley P. Boue, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

ROBERT E. KEATLEY Registrar

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

2 44424

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2405 N. Calvert ST.: 12 WARD)

2-FULL NAME William Elliott Landman

(a) RESIDENCE. No. 2405 N. Calvert ST.: 12 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or WIFE of)

Lillian L. Landman

6 DATE OF BIRTH (month, day, and year)

Nov. 11-1892

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47

7

49

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

bank clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

Seller. 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

William H. Landman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Maryland

12 MAIDEN NAME OF MOTHER

Maudie H. Hatcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Maryland

14

Informant (Address)

Lillian L. Landman 2405 N. Calvert St.

15

JUL 1 - 1920

ROBERT A. KRAVITZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 30 1920

17

I HEREBY CERTIFY, that I attended deceased from

June 1917, to June 30, 1920.

that I last saw him alive on June 28, 1920.

and that death occurred, on the date stated above, at 12:00 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of spinal column

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. S. Watson, M. D.

July 1, 1920 (Address) 2128 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenwood Cem. July 2 1920

20 UNDERTAKER

ADDRESS

H. E. Hughes - 178 Bway

1044425

HEALTH DEPARTMENT—CITY OF BALTIMORE

64-1044425

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

208, S. Ann

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John Bogdan

(a) RESIDENCE. NO.

208, S. Ann

ST.

WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. 0 ds.

How long in U. S., if of foreign birth? 35 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

59

0

0

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Laborer. 040

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Farm work.

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Galicia

10 NAME OF FATHER

Joseph Bogdan

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Galicia

12 MAIDEN NAME OF MOTHER

Jadwiga Geldg.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Galicia

14

Informant
(Address)Mary Kerner
208 S. Ann

15

Filed

JUL 1 - 1920

ROBERT E. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 30 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 22, 1920, to June 29, 1920,

that I last saw him alive on June 29, 1920,

and that death occurred, on the date stated above, at 12:30 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage -
(long time playing)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY
(Secondary)

Coma -

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Schmeier - M. D.

, 19 (Address) 1258 Broadway -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus

7/3 1920

20 UNDERTAKER

ADDRESS

William Giesford 1618 E

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

JUL 1 - 1920

ROBERT A. KRAUTH

BRIAN PAULIE DICK

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

4 - 7, 1920, to 6 - 30, 1920

that I last saw him alive on 6 - 31, 1920

and that death occurred, on the date stated above, at 8:00 P. M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis with hypertension and cardiac hypertrophy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocarditis and acute dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel P. Aldrich, M. D.

19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Last statement on back of certificates. See instructions on back of certificates.

D. 44427 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 44427

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Little Sisters of the Poor

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.;

10

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Johanna Hughes

(Residence in Baltimore: No.

Little Sisters of the Poor

St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-STATUS

MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Wid.

6-DATE OF BIRTH,

unknown

1851

(Month)

(Day)

(Year)

7-AGE,

69

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Newfoundland

10-NAME OF FATHER,

Edward Flynn

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

Bridget Milligan

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Sister Benedict

(Address)

Little Sisters of the Poor

15-

Filed

1-1921 Robert P. Harrison,

191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 30th, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I saw h alive on 191

and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Anthrax back of neck
2 weeks (Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) F. A. Warner M. D.

June 30, 1920 (Address) 1133 Barclay St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 8 yrs. 4 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL

DATE OF BURIAL,

Cathedral July 2, 1920

20-UNDERTAKER

ADDRESS

H. C. Widdifield 914 Greenmount

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

244428 HEALTH DEPARTMENT—CITY OF BALTIMORE 105 ✓ 0.44428

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3502 Hudson ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Meskill Diety

(a) RESIDENCE. No.

(Usual place of abode)

(a) RESIDENCE. No. 3502 Hudson ST., 26 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

6 If married, widowed, or divorced

(or) WIFE of

Philip

Diety

7 DATE OF BIRTH (month, day, and year)

May 17 1905

7 AGE

25

Years

Months

12

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Patrick Meskill

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Jenny Shea

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Patrick Meskill

15

Filed

Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 29 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 28, 1920, to June 29, 1920,

that I last saw her alive on June 29, 1920,

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

exhaustion following acute gastric enteritis

(duration) 1 yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. V. Wright, M. D.

for 1920 Address 3048 Abigail St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Sacred Heart Cem.

DATE OF BURIAL

July 1 1920

20 UNDERTAKER

Lilly and Zeiler

ADDRESS

403 S. Wolfe St.

D. 44429 HEALTH DEPARTMENT—CITY OF BALTIMORE D44429

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1220 W. Lafayette ave. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

James A. Dawkins

(a) RESIDENCE. NO. 1220 W. Lafayette ave. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 9 mos. 8 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Mary L. Dawkins

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 74 Months 9 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Commission

(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant

(c) Name of employer

Tobacco

9 BIRTHPLACE (city or town). (State or country)

Maryland

10 NAME OF FATHER

Young P. Dawkins

11 BIRTHPLACE OF FATHER (city or town). (State or country)

Md

12 MAIDEN NAME OF MOTHER

Alathia Dorsey

13 BIRTHPLACE OF MOTHER (city or town). (State or country)

Md

14

Informant

Mary L. Dawkins

(Address)

1220 W. Lafayette ave.

15

Filed

JUL 1 - 1920

Robert P. Charlton,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-30 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 9, 1920, to June 29, 1920.

that I last saw him alive on

June 29, 1920.

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Chr. Inflammatory Arthritis

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Mitral Regurgitation

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

X

Did an operation precede death?

X

Date of X

Was there an autopsy?

No

What test confirmed diagnosis?

Physical Ex.

(Signed)

E. H. Murray, M. D.

1220 W. Lafayette ave.

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery July 2, 1920

20 UNDERTAKER

ADDRESS

John Mitchell 1220 W. Lafayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44430

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Charles St. - Greenway Apartment ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. Liggett)St.; 28 yrs., 4 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH,

Oct 8, 1891
(Month) (Day) (Year)

7-AGE,

28 yrs., 4 mos., 22 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).not emp.
invalid9-BIRTHPLACE.
(State or Country),

Baltimore Md

10-NAME OF FATHER,

Milward S. Black

11-BIRTHPLACE OF FATHER
(State or Country),

Balt Md

12-MAIDEN NAME OF MOTHER

Ella Hooper

13-BIRTHPLACE OF MOTHER
(State or Country),

Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eduard Hill Black

(Address)

Owings Mills

15-

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

June 30, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1920, to June 30 1920, that I saw him alive on June 29 1920, and that death occurred, on the date stated above, at 4:20 m. The CAUSE OF DEATH* was as follows:
Sarcoma of RectumProbable (Duration) 2 yrs. 1 mos. 1 ds.CONTRIBUTORY
(Secondary)(Duration) 2 yrs. 1 mos. 1 ds.(Signed) John D. King M. D.June 30, 1920 (Address) 1425 E. Main St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Louden Park July 2, 1920

20-UNDERTAKER

John Mitchell 1425 E. Main St.

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19-H. P. Co. 1000 Bka.

D. 44431

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44431

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2207 Harper St. 13 WARD)

2-FULL NAME

(a) RESIDENCE. No. 2207 Harper St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If nonresident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30 1920

7 AGE Years Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Joseph Mergl

11 BIRTHPLACE OF FATHER (city or town) Bohemia (State or country)

12 MAIDEN NAME OF MOTHER Regina Blum

13 BIRTHPLACE OF MOTHER (city or town) Bohemia (State or country)

14

Informant (Address) 2207 Harper St.

15

Filed 1920

19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1920

17

I HEREBY CERTIFY, that I attended deceased from

June 30 1920 to June 30 1920

that I last saw him alive on June 30 1920

and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Præcordial Arrest

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Keane, M. D.

(Address) 801 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

July 1 1920

20 UNDERTAKER

ADDRESS

Frank Brackley

1966 N. Broadway

JOHN URBANSKI
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 Lancaster ST.; 2 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

John Urbanski
(Residence in Baltimore: No. 1808 Lancaster St.; 2 yrs. 7 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

M

4-COLOR OR RACE,

White5-SINGLE, Single
~~MARRIED,~~
~~WIDOWED,~~
~~OR DIVORCED,~~
(Write the word.)

6-DATE OF BIRTH,

Jan 24, 1920.
(Month) (Day) (Year)

7-AGE,

7 yrs. 7 mos. 7 ds.
If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),Baltimore, Md.,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Urbanski,
(Address) 1808 Lancaster Street

15-

Filed 1-1920 Robert P. Harrison,
191 Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 1, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 24 1920, to July 1 1920,that I saw him alive on July 3 1920,and that death occurred, on the date stated above, at 7:10 m.

The CAUSE OF DEATH* was as follows:

Congenital Weakness

(Duration) yrs. mos. ds.

CONTRIBUTORY Pneumonia Blood (6mo)
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Harrison M. D.July 1, 1920 (Address) 165 Brady

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus Cemetery

DATE OF BURIAL,

July 1, 1920

20-UNDERTAKER

M. F. Sudowski

ADDRESS

75 S. Ann St

important. See instructions on back of certificate.

D. 44433

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44433

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.:

WARD)

2-FULL NAME Henry Maier(a) RESIDENCE. NO. Unknown

(Usual place of abode)

ST.:

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

Male

White

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1866

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

54

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Butcher

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Unknown

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town)
(State or country)

Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Unknown

14

Informant
(Address)

Hospital Records,

New City Hospital

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 29, 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 28, 1920, to June 29, 1920.

that I last saw him alive on June 29, 1920.

and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Generalized arterio-
sclerosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Endocarditis obliterans

(duration) 3 yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test, confirmed diagnosis? No special test.

(Signed) J. B. H. M. D.

June 29, 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

JUL 1-1920

12328

D. 44434 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 44434

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 Abbottston

ST.: 9

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

May G. Pletsch

(a) RESIDENCE. NO. 1609 Abbottston

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Charles H. E. Pletsch

6 DATE OF BIRTH (month, day, and year)

June 23rd 1870

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

30

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

Maryland

10 NAME OF FATHER

John L. Mergler

11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Elena Vogt

13 BIRTHPLACE OF MOTHER (city or town)

Rochester

(State or country)

New York

14

Informant (Address)

Charles H. E. Pletsch 1609 Abbottston St.

15

Filed

Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 30 1920

17

HEREBY CERTIFY, That I attended deceased from

July 1, 1919, to June 30, 1920,

that I last saw him alive on

June 19,

and that death occurred, on the date stated above, at

925 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Vascular Disease

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

albumenuria. Int. Anemia

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

Geo. W. Noetting

M. D.

, 1920 (Address)

5835 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mountained Crematory July 2 1920

20 UNDERTAKER

ADDRESS

Frederick Cassin & Son

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *515 Norris St*)ST.: *19* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Irene Burkes*(a) RESIDENCE. NO. *515 Norris*

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *9* yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Blk* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed or divorced HUSBAND of (or) WIFE of *Jeremiah Burkes*6 DATE OF BIRTH (month, day, and year) *May 22 1920*7 AGE Years Months Days *28* — *11* — *—* If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Media Co Virginia*
(State or country)10 NAME OF FATHER *Edw Johnson*11 BIRTHPLACE OF FATHER (city or town) *Va*
(State or country)12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) *Va*
(State or country)14 Informant *Jeremiah Burkes*
(Address) *515 Norris St*15 Filed *Robert P. Harrison,*

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *6/20* 19*20*17 I HEREBY CERTIFY, That I attended deceased from *May 22*, 19*20*, to *June 30*, 19*20*, that I last saw her alive on *June 29*, 19*20*, and that death occurred, on the date stated above, at *4 30 P.* m. The CAUSE OF DEATH* was as follows:*Typhoid Fever*(duration) yrs. mos. ds. *38*CONTRIBUTORY (Secondary) *Hemorrhage*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *unknown*Did an operation precede death? *No* Date of *—*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Eustas G. W. Duncan* M. D.19 (Address) *656 N. Franklin*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Wellsville Cemetery Co Va*

20 UNDERTAKER

JAMES H. DENNIS

ADDRESS

1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

U1

1-1920

044436

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.

2526 E. Biddle St.

WARD) 8

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Conrad Joseph Weber

(Residence in Baltimore: No.

2526 E Biddle St.

St.; 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

6-DATE OF BIRTH

June 10 1855
(Month) (Day) (Year)

7-AGE

65 yrs. 20 ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Varnisher 051
Furniture Factory9-BIRTHPLACE
(State or country)

Baltimore County Md

PARENTS

10-NAME OF FATHER

Nicholas Weber

11-BIRTHPLACE OF FATHER
(State or country)

Germany

12-MAIDEN NAME OF MOTHER

Caroline Reiter

13-BIRTHPLACE OF MOTHER
(State or country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Agnes Peter

(Address)

2526 E Biddle St.

15-

Robert P. Harrison,

Burial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

June 30 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 13, 1920, to June 30 1920, that I saw him alive on June 30 1920, and that death occurred, on the date stated above, at 9:30 P. M.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)

Broncho Pneumonia

(Duration) yrs. mos. ds.

(Signed),

June 30 1920

Thos J. Stevens M. D.

[Address] 2566 Kenilworth Rd.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Holy Redeemer

DATE OF BURIAL

July 3- 1920

20-UNDERTAKER

Wm. Cook

ADDRESS

502 S. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

57 yrs.

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1920

17 I HEREBY CERTIFY, That I attended deceased from
Monday 12 1920, to July 12 1920,
that I last saw him alive on June 30 1920,
and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pericious Anemia

CONTRIBUTORY
(Secondary)

(duration) one yrs. mes. ds.

(duration) one yrs. mes. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

July 1, 1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced (write the word)

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Lena Young

6 DATE OF BIRTH (month, day, and year)

June 30, 1863

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

57

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Moulder. 010

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Brick Moulder.

(c) Name of employer

Baltimore Co.

9 BIRTHPLACE (city or town)
(State or country)

George M. Young.

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Lena Seidel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore.

14

Informant
(Address)Lena Young
1805 N. Pratt

15

Filed

1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.44438 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2744 Fenwick Ave. ST. 9 WARD)2-FULL NAME Caroline Lowry Hutchins(a) RESIDENCE. No. 2744 Fenwick Ave. ST. 9 WARD. (Resident)

(Usual place of abode)

Length of residence in city or town where death occurred 85 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? 85 yrs. 11 mos. 16 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofJames Alfred Hutchins6 DATE OF BIRTH (month, day, and year) July-15-1834

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.851116

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None9 BIRTHPLACE (city or town)
(State or country)Baltimore
Maryland

10 NAME OF FATHER

Henry Herwing

11 BIRTHPLACE OF FATHER (city or town)

Baltimore
Maryland

12 MAIDEN NAME OF MOTHER

Lousia Lowry

13 BIRTHPLACE OF MOTHER (city or town)

Phila.
Penna.

PARENTS

14 Informant

(Address)

Mrs E. Clay Timanus (daug. fil.)
4431 Roland Ave

15

Filed

Robert P. Harrison,

Registrar

JUL 1 - 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-1 1920

17

I HEREBY CERTIFY, That I attended deceased from

1915 to July 1, 1920that I last saw her alive on July 1, 1920and that death occurred, on the date stated above, at 1450 m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis(duration) yrs. mos. 8 ds.CONTRIBUTORY
(Secondary)Arterio Sclerosis(duration) 3 yrs. - mos. - ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Stanley M. Meleny, M. D., 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. James Cemetery - My Lady Manor - Balto. Co.7/3/1920

20 UNDERTAKER

STEWART & MOWEN COMPANY

ADDRESS

(WILLIAM F. RUDDEN, Successor)

108 W. NORTH AVE.

D. 44439 HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44439

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 Mosher ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 50 yrs. 6 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

1-1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June - 30 1920

17

I HEREBY CERTIFY, That I attended deceased from

, 19 10, to June 30, 19 20,

that I last saw him alive on , 19

and that death occurred, on the date stated above, at 8.00 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary hemorrhage following tuberculosis of lung

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? microscope

(Signed) Geo. A. Fleming, M. D.

, 19 (Address) 1018 Madison Ave

*State the Disease Causing Death, or in deaths from Violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cemetery

July - 3/ 1920

20 UNDERTAKER

STEWART & MOWEN COMPANY

(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(26 N. Howard st)
D. 44440 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 44440

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *on St. Ann's Hospital* 15 WARD) REGISTERED No. C
2-FULL NAME *Felix J. Surovic* (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(Residence in Baltimore: No. *1805 Broadush* *Life* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)
6-DATE OF BIRTH, *March 15, 1868* (Month) (Day) (Year)
7-AGE, *52 yrs. 3 mos. 15 ds.* If LESS than 1 day,hrs. or....min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Bookkeeper*
(b) General nature of industry, business, or establishment in which employed (or employer) *008*
9-BIRTHPLACE, (State or Country), *Balt Md*
PARENTS.
10-NAME OF FATHER, *Jacob Surovic*
11-BIRTHPLACE OF FATHER, (State or Country), *Germany*
12-MAIDEN NAME OF MOTHER, *Mina Mose*
13-BIRTHPLACE OF MOTHER, (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Harrison*
(Address) *221 N. Broadway*

15- Robert P. Harrison,
Filed *1-1920* 191...
Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 30, 1920* (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest, autopsy or inquiry.* thereon and from the evidence obtained by said *Inquest, autopsy or inquiry.* find that said deceased came to *this* death on the day stated above.
The CAUSE OF DEATH* was as follows:
Valvular Heart disease
(Duration) *Don't know* yrs. mos. ds.
CONTRIBUTORY *Don't know* (Secondary)
(Duration) *Don't know* yrs. mos. ds.
(Signed) *H. J. Harrison* M. D. (Coroner.)
7-1, 191 (Address) *112 N. Broadush*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Hebrew Friendship* DATE OF BURIAL, *July 2, 1920*

20-UNDERTAKER, *J. Ahrens & Co* ADDRESS, *1611 Mad*

and

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

44441 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044441

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2822 Harlem Ave ST. 16 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Mary Elizabeth Gerhold
(Residence in Baltimore: No. 2822 Harlem Ave St. 49 yrs. 5 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female	4-COLOR OR RACE, white	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, married (Write the word.)
6-DATE OF BIRTH January 3, 1871 (Month) (Day) (Year)		
7-AGE, 49 yrs. 5 mos. 26 ds.		If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. Housewife (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE, (State or Country), Balto. Md.		
PARENTS.	10-NAME OF FATHER, Frank Young	
	11-BIRTHPLACE OF FATHER (State or Country), Germany	
	12-MAIDEN NAME OF MOTHER, Muberson	
	13-BIRTHPLACE OF MOTHER (State or Country), Germany	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John C. Gerhold
(Address) 2822 Harlem Ave.

15- JUL 2 - 1920 ROBERT E. KRAUTER
Filed 101-20121-10000

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 29, 1920 (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, thereon and from the evidence obtained by said inquest, and that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows:
(Asphyxia (Poisoning) Suicide)
(Duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) ...
(Signed) J. D. Hammersy M. D. (Coroner.)
June 29, 1920 (Address) 2802 Edmonson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place in the
of death ... yrs. ... mos. ... ds. State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park
20-UNDERTAKER, Mrs. John W. Teufel 1801 W. Fayette

DATE OF BURIAL, July 2, 1920
ADDRESS

1044442

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044442

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph Hospital*)ST.: *6*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Clema Williams*(a) RESIDENCE. NO. *417 N. Belhel*
(Usual place of abode)

ST. — WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *18* yrs. mos. ds. How long in U. S., if of foreign birth? *18* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Cordoba* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of *Widow*6 DATE OF BIRTH (month, day, and year) *Unknown*7 AGE Years Months Days
38 — —
If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House Worker*(b) General nature of industry, business, or establishment in which employed (or employer) *House Worker*

(c) Name of employer

9 BIRTHPLACE (city or town) *Beltsville, Md.*
(State or country) *MD*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) *Unknown*
(State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Unknown*
(State or country) *Unknown*14 Informant *from friend, John Jones*
(Address) *1735 Ashland St*15 *JUL 2 - 1920*
ROBERT E. KANTER
Registrar
Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *June 29* 19 *20*17 I HEREBY CERTIFY, That I attended deceased from *June 20*, 19 *20*, to *June 27*, 19 *20*, that I last saw him alive on *June 28*, 19 *20*, and that death occurred, on the date stated above, at *6:15 P.M.*

The CAUSE OF DEATH* was as follows:

*Cardiac Insufficiency*CONTRIBUTORY (Secondary) *Bronchitis*
(duration) yrs. mos. ds. *1* ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Autopsy*
(Signed) *F. C. Martin*, M. D., 19 (Address) *St. Joseph Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Int-Aurum Cemetery *July 2* 19 *20*20 UNDERTAKER *Mrs R A Elliott* ADDRESS *1725 Ashland St*

TION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Ills.

1044443 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044443-64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: No. 221 N. Spring ST.: 5 WARD)

2-FULL NAME Rebecca Stringfellow

(a) RESIDENCE. No. 221 N. Spring ST., 5 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dead 1860

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE Years 60 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover Co.

10 NAME OF FATHER Isaac Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Julia Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant John Stringfellow (Address) 1202 Park Ave

15 Filed JUL 2 - 1920 ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1920

17 I HEREBY CERTIFY, That I attended deceased from 1 - 1 - 1920, to 6 - 29 - 1920, that I last saw her alive on 6 - 28 - 1920 and that death occurred, on the date stated above, at 8:40 P. m.

The CAUSE OF DEATH* was as follows: Pt. Haemiplegia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonic Arterium (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 604 E. Madison St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical (Signed) Sol. C. Katsch M. D.

50 1920 (Address) 116 W. 1st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER Samuel H. Hensley ADDRESS 578 W. Baltimore

1044444 HEALTH DEPARTMENT—CITY OF BALTIMORE

1044444

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 Front St. 5 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Goodman

(Residence in Baltimore: No. 1007 Front St. 52 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

(Month) (Day) (Year) 1

7-AGE,

52 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9-BIRTHPLACE, (State or Country),

Balto. Md.

PARENTS.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Morris Newman

(Address) 3605 Cottage Ave

15-

Filed

JUL 2 - 1920

ROBERT B. KHAUTER

Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 1st, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1st 1920 to July 1st 1920, that I saw him alive on July 1st 1920, and that death occurred, on the date stated above, at 1047 N.

The CAUSE OF DEATH* was as follows:

Mental Insufficiency

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Joseph H. Newman M. D.

July 1st 1920 (Address) 1634 E. Balt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? 10011 Front St

Former or usual residence 1007 Front St

19-PLACE OF BURIAL OR REMOVAL

Balto Hebrew Unit

DATE OF BURIAL

July 2, 1920

20-UNDERTAKER

Sol. Linson

ADDRESS

1919

Madison Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

10-44445

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital. ST.: 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Milroy or Kanderer.(a) RESIDENCE. NO. 530 W. Conway St. ST. 22 WARD. 22
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louise Milroy6 DATE OF BIRTH (month, day, and year) 18527 AGE Years Months Days If LESS than 1 day, hrs. or min.
68

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)10 NAME OF FATHER John Milroy11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)12 MAIDEN NAME OF MOTHER Unknown July 1, 192013 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.
(State or country)14 Informant Hospital Records
(Address) New City Hospital.15 JUL 2 - 1920 ROBERT F. REAGAN

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 192017 I HEREBY CERTIFY, That I attended deceased from June 25, 1920, to July 1, 1920,
(that I last saw him alive on July 1, 1920,
and that death occurred, on the date stated above, at 2:15 P. m.
The CAUSE OF DEATH* was as follows:Cerebral hemorrhage.(duration) yrs. mos. ds. 3. ds.CONTRIBUTORY Broncho-pneumonia
(Secondary) (terminal) (duration) yrs. mos. ds. 2. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? No special test(Signed) R. B. ERMAN M. D.(Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Lansdown Park Cemetery Aug 3 1920

20 UNDERTAKER ADDRESS

for funeral. Son 2175 Penn

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1033 Vincent ST.: 16 WARD.)

2-FULL NAME

James Reynolds

(a) RESIDENCE. No.

1033 Vincent ST.: _____ WARD. _____

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of Carrie Reynolds (or WIFE of _____)6 DATE OF BIRTH (month, day, and year) Feb 10 18707 AGE Years 50 Months 4 Days 30 If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

JUL 2 - 1920

ROBERT A. BRAUTER

Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 192017 I HEREBY CERTIFY, That I attended deceased from June 5 1920 to June 30 1920, that I last saw him alive on June 29 1920 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease(duration) 1 yrs. 6 mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. William Fry M. D.630, 1920 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

MT Auburn Cemetery July 3d 1920

20 UNDERTAKER

ADDRESS

JAMES H. DENNIS

1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 44447

408 44447

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....9-BIRTHPLACE,
(State or Country),10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country),12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

2-

1920

ROBERT E. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 21, 1920, to June 29, 1920,

that I saw her alive on June 27, 1920,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Breast Cancer

(Duration).....yrs.....mos.....da.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....da.

(Signed).....James M. Hayes.....M. D.

6/29/20 (Address).....513 N. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Auburn July 2d, 1920

20-UNDERTAKER

ADDRESS

JAMES H. DENNIS

1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44448
175-2 44448
PLACE OF DEATH
CITY OF BALTIMORE (No. 2622 Hayford Road. 9 WARD)
FULL NAME James J. Magann.
(Residence in Baltimore No. 2622 Hayford Road. 9 WARD)
REGISTERED No. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single
6-DATE OF BIRTH, Sept. 26, 1895
7-AGE, 24 yrs. mos. ds.
8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country), Baltimore Md.
10-NAME OF FATHER, Michael Magann.
11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.
12-MAIDEN NAME OF MOTHER, Mary T. Mahoney
13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Magann.
(Address) 2622 Hayford Road.

15-JUL 2-1920

Filed.....

101

ROBERT A. KRAUTER

DEPUTY CITY CLERK

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry, thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pneumonia, ran course
trauma
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. J. Magann, M. D.
(Coroner)
7-1-1920 Address: 175-2 44448

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

New Cathedral Cemetery July 3rd 1920

20-UNDERTAKER, ADDRESS

George J. Reith, 735 Hayford Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 35 Eastern Ave ST.; 1 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 22 35 Eastern Ave St.; 1 yrs., 1 mos., 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)Single

6-DATE OF BIRTH.

May 6, 1919
(Month) (Day) (Year)

7-AGE.

1 yrs., 1 mos., 25 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).None9-BIRTHPLACE,
(State or Country).Baltimore

10-NAME OF FATHER.

Frank Kwiatkowski11-BIRTHPLACE OF FATHER
(State or Country).Germany

12-MAIDEN NAME OF MOTHER

Miklosa Majerowski13-BIRTHPLACE OF MOTHER
(State or Country).Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miklosa Kwiatkowski
(Address) 22 35 Eastern Ave

15-

JUL 2 - 1920

ROBERT B. KRAFTER

BUREAU OF VITAL RECORDS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 1, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

June 11, 1920, to July 1, 1920,that I saw him live on 1 19120and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Lober Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Chas. J. Neer M. D.7/1/20 191... (Address) 408 2nd St. N. W.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Holy Rosary

DATE OF BURIAL.

7/2, 1920

20-UNDERTAKER

W. J. Kowalski 1618 Eastern Ave

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Providence Hospital* ST. *17* WARD)2-FULL NAME *Benjamin Maynard*(a) RESIDENCE, No. *1138* ST. *Argyle Ave.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *40* yrs. — mos. — ds.

How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *Caucasian*5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *Aug. 7, 1880*

7 AGE

Years *40*Months *10*Days *25*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *Benjamin Maynard*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Caldwell Co. Md.*12 MAIDEN NAME OF MOTHER *Margaret White*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

14

Informant (Address) *Dr. H. H. Hartman, M. D., 1216 Union St. N. E.*

15

JUL 2 - 1920

ROBERT E. KRAUTER Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 2* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

June 27, 1920 to *July 2, 1920*
that I last saw him alive on *July 1, 1920*and that death occurred, on the date stated above, at *6 A. M.*

The CAUSE OF DEATH* was as follows:

Acute Myocarditis
(duration) *1* yrs. *6* mos. *6* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Dr. H. H. Hartman*, M. D.(Address) *1216 N. H. Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*W. C. Auburn Cemetery**July 4* 19 *20*

20 UNDERTAKER

*John J. Johnson*ADDRESS *284 E. 1st St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

244451

CERTIFICATE OF DEATH.

91844451

PLACE OF DEATH
CITY OF BALTIMORE (No. 1922 Division ST. 14 WARD)
FULL NAME Bernice Willis
(Residence in Baltimore: No. 1922 Division St.; yrs., 13 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male
4-COLOR OR RACE, black
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, single
6-DATE OF BIRTH, May 30, 1919
7-AGE, 1 yrs., 1 mos., 1 da.
8-OCCUPATION: (a) Trade, profession, or particular kind of work, Seafarer
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Balto. Md.
10-NAME OF FATHER, Edward Willis
11-BIRTHPLACE OF FATHER, (State or Country), Virginia
12-MAIDEN NAME OF MOTHER, Mamie Evans
13-BIRTHPLACE OF MOTHER, (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward Willis
(Address) 1922 Division St.

15- JUL 2 - 1920
Filed, 191. ROBERT B. KRAUTH
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cause of Death, Infection of lungs
(Duration) yrs. mos. ds.
(Signed) J. S. D. Hennessey, M. D.
(Coroner)
July 1, 1920 (Address) 2802 E. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery
DATE OF BURIAL, July 2, 1920
20-UNDERTAKER, J. W. Johnson
ADDRESS, 1230 E. King St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

844452

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2419 Stockton

ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2419 Stockton

St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

unknown

(Month)

(Day)

(Year)

7-AGE

47

yrs.

mos.

ds.

IF LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Driver

9-BIRTHPLACE,
(State or Country),

Maryland

10-NAME OF FATHER,

William Young

11-BIRTHPLACE OF FATHER

(State or Country),

Not Known

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER

(State or Country),

" "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Adeline Young (wife)

(Address)

2419 Stockton St.

15-

ROBERT B KRAUTER

JUL 2 - 1920

191.

Burial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 29, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 1, 1920, to June 29, 1920,

that I saw him alive on June 29, 1920,

and that death occurred, on the date stated above, at 8:45 P.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) T. E. Daugherty M. D.

June 30, 1920 (Address) 1602 Parkview Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn

DATE OF BURIAL,

July 3, 1920

20-UNDERTAKER

Edward Ringgold

ADDRESS

1463 N. Bay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1244453

HEALTH DEPARTMENT—CITY OF BALTIMORE

1244453

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1308 E. Pratt St. ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MANIVAN STEINBERG

(a) RESIDENCE. No. 1308 E. Pratt St.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 1 mos.

ds. How long in U. S., if of foreign birth?

yrs. 1 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5 - 1920

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md

10 NAME OF FATHER Harry Steinberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Pearl Druskitch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1411 E. Pratt St

15 JUL 2 - 1920 ROBERT B. FRADTKE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1920

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1920, to July 2, 1920, that I last saw him alive on July 1, 1920, and that death occurred, on the date stated above, at 10:30 A.M. The CAUSE OF DEATH* was as follows: Broncho Pneumonia

CONTRIBUTORY (Secondary) Bronchitis (duration) yrs. 15 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. J. Baylin M. D.

42, 1920 (Address) 1411 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Andrew's Episcopal Church July 2, 1920

20 UNDERTAKER ADDRESS

Jack Lewis, 1411 E. Pratt St

1044454

HEALTH DEPARTMENT—CITY OF BALTIMORE

10444454

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.;

yrs.,

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

Filed

JUL 2 - 1920

ROBERT A. KRAUTER

BUTLER PRINTING CO.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 28 1920, to July 2 1920,

that I saw him alive on July 1st 1920,

and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Dysentery & enteritis

.....

.....

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

July 2, 1920 (Address) 211 Church St.

.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

.....

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cedar Hill Cemetery July 3, 1920

20-UNDERTAKER ADDRESS

Geo. A. Gerbig 2001 W. Baltimore St.

.....

.....

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION if very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 N Port st ST. 6 WARD)

2-FULL NAME

William R McDonald(Residence in Baltimore: No. 229 N Port st

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 27 yrs. 1 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) single

6-DATE OF BIRTH.

June 1st, 1893
(Month) (Day) (Year)

7-AGE,

27

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

clerk

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Thomas E McDonald

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Annie Ruben

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie McDonald(Address) 229 N Port st

15-

Filed 2-1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 1, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1919, to July 1 1920,that I saw him alive on July 1 1920,and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Phthisis
(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Arthur P. Deane, M. D.
1920 (Address) 2400 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn Cem

DATE OF BURIAL,

July 5, 1920

20-UNDERTAKER

Mrs C Miller

ADDRESS

2334 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 970th Callington ST. 7 WARD)

2-FULL NAME

Christopher E. Dunn(Residence in Baltimore: No. 970th Callington ave St.; 72 yrs., 6 mos., 6 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH.

Jan 6th, 1848
(Month) (Day) (Year)

7-AGE.

72If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Watchman
667

9-BIRTHPLACE, (State or Country).

Maryland

10-NAME OF FATHER.

Paul Dunn

11-BIRTHPLACE OF FATHER (State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

Margaret Morrison

13-BIRTHPLACE OF MOTHER (State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Robert P. Harrison

(Address)

245th Lenox ave

15-

2-1920 Robert P. Harrison,

Filed

191

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 12 19120, to June 30 19120,that I saw him alive on June 30 19120,and that death occurred, on the date stated above, at 5:45 m.

The CAUSE OF DEATH* was as follows:

Nephritis, hypertensive
if renal / hypercalcemia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) T. Morrison M. D.6-30-20 19120 (Address) 800 N. Patterson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Baltimore Cemetery

DATE OF BURIAL.

July 3, 1920

20-UNDERTAKER

Miss C. Miller

ADDRESS

2334 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

1512 44458

REGISTERED NO. C

ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

John Kresner

St.; yrs., mos. *14* ds.)

MEDICAL CERTIFICATE OF DEATH.

5-SINGLE,
MARRIED,
WIDOWED, *Single*
OR DIVORCED.
(Write the word.)

..... 15, 1980
(Month) (Day) (Year)

Yrs. mos. 14 da.

If LESS than 1 day,
....hrs. or....min.?

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

Baltimore

Wilhelm Kresse

13442

Besse Penning

Bald

(Informant) Allen, Robert

(Address) 1824 East a

Robert P. Harrison,

Filed JUL 2 - 1926

....., 191.....

Registrar.
Daniel Permit Clerk.

..... July 2, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
June 30 1920, to June 30 1920,
that I saw h^e alive on June 30 1920,
and that death occurred, on the date stated above, at 5 a. m.
The CAUSE OF DEATH* was as follows:

...Innovation.....

..... (Duration) yrs..... moa.. 0 .. ds.

(Signed).....*L. J. Sussman*.....M. D.

1366281920. (Address) 722 S. ... Kansas ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?.....

Former or
usual residence

DATE OF BURIAL,

St. Stanislaus

July 3", 1926

20-UNDERTAKER

M. F. Sadowski

ADDRESS

408 L. Ann

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 44459 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 44459

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 705 E Preston ST. 10 WARD)

2-FULL NAME Martin Connor Sr.

(Residence in Baltimore: No. 705 E Preston St.; yrs., mos. ds.)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct 1, 1841 (Month) (Day) (Year)

7-AGE, 78 yrs. 9 mos. ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None (b) General nature of industry, business, or establishment in which employed (or employer). Retired

9-BIRTHPLACE, (State or Country), Ireland

10-NAME OF FATHER, John Connor

11-BIRTHPLACE OF FATHER, (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Elizabeth Dunn

13-BIRTHPLACE OF MOTHER, (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bridget Connor

(Address) 705 E Preston St.

15- Robert P. Harrison,

Filed JUL 8 - 1920 191 Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 1, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of hip, by fall on pavement, done by small boy running with him. Accident (Duration) yrs. mos. ds. 13 ds.

CONTRIBUTORY (Secondary) old age

(Duration) yrs. mos. ds.

(Signed) James M. Connor M. D. (Coroner.)

July 1, 1920 (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem

DATE OF BURIAL, July 5, 1920

20-UNDERTAKER, Chas J. Evans & Son, 118 W. N. Royal Ave

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital*)ST.: *7*

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Baby Harris*(Residence in Baltimore: No. *Hebrew Hospital*)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female*4-COLOR OR RACE, *W*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*6-DATE OF BIRTH, *May 12*, 19*20*

(Month)

(Day)

(Year)

7-AGE, *1* yrs., *18* mos., *18* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.....
-
- (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *U.S.*10-NAME OF FATHER, *John Henry Harris*11-BIRTHPLACE OF FATHER (State or Country), *U.S.*12-MAIDEN NAME OF MOTHER *Katharine McKinley*13-BIRTHPLACE OF MOTHER (State or Country), *U.S.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Robert P. Harrison, *JOHNS HOPKINS HOSPITAL*

Burial Permit Clerk, Registrar.

17332

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *June 30*, 19*20*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

19*1*

, to

19*20*that I saw him alive on *June 30*, 19*20*and that death occurred, on the date stated above, at *9 a.* m.

The CAUSE OF DEATH* was as follows:

Congenital debility

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) *unknown*

(Duration)..... yrs..... mos..... ds.

(Signed) *Nancy Goodman* M. D.*6-30*, 19*20*. (Address) *Hebrew Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL, *July 2*, 19*20*20-UNDERTAKER *Commissioner Health*

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificate.

JUL 2 1920

D. 44461

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44461

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 Dennison St. ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

FRANK LOESCHKE

(a) RESIDENCE. NO. 610 Dennison ST. 16 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) June 29, 19207 AGE Years Months Days If LESS than 1 day, 12 hrs. or min. 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md.
(State or country)10 NAME OF FATHER Paul H. Loeschke11 BIRTHPLACE OF FATHER (city or town) Balto, Md.
(State or country)12 MAIDEN NAME OF MOTHER Margaret Debo13 BIRTHPLACE OF MOTHER (city or town) Balto, Md.
(State or country)14 Informant Mr. Paul H. Loeschke
(Address) 610 Dennison St.15 Filed 1920 Robert P. Harrison,
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 192017 I HEREBY CERTIFY, that I attended deceased from July 1st, 1920 to July 2nd, 1920,
that I last saw him alive on July 1st, 1920,
and that death occurred, on the date stated above, at 4.45 P. M.
The CAUSE OF DEATH* was as follows:Asphyxia
ProCONTRIBUTORY (Secondary) Prolonged Labor
(duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death? ✓Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis
(Signed) Edw. J. Temple M. D.
, 19 (Address) 517 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Cemetery July 2, 1920

20 UNDERTAKER ADDRESS

Joe Janssens & Son 217 S. Paca

Cause of death should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 U. Wolfe ST.: 6 WARD)2-FULL NAME Rolph Davidson(a) RESIDENCE. No. 108 U. Wolfe ST.: — WARD.

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 24 mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. 91

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced (write the word) Infant5a If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) June 8, 1920

7 AGE

Years —Months —Days 24If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) —(c) Name of employer —9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)10 NAME OF FATHER Meyer Davidson11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)12 MAIDEN NAME OF MOTHER Roy Abrams13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14

Informant (Address) Meyer Davidson

15

Filed

Robert P. Harrison,

19

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-2 1920

17

I HEREBY CERTIFY, That I attended deceased from June 29, 1920 to July 2, 1920,
that I last saw him alive on July 2, 1920,
and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted 108 U. Wolfe
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical Exam(Signed) M. L. Lumen M. D.7/2/1920 Address 38 W. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew BurialDATE OF BURIAL July 2, 192020 UNDERTAKER myADDRESS E. Dalton

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

JUL 2-1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 Hollins ST.; 18 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1218 Hollins St.; 3 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, M 4-COLOR OR RACE, W 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, 9 1 1920
(Month) (Day) (Year)

7-AGE, about 45 yrs. mos. ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Italy -

10-NAME OF FATHER, Italy -

11-BIRTHPLACE OF FATHER (State or Country), Italy -

12-MAIDEN NAME OF MOTHER, Italy -

13-BIRTHPLACE OF MOTHER (State or Country), Italy -

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) San Camapano(Address) 1402 W. Ball St.

15- Robert P. Harrison,

JUL 2 - 1920 Burial Permit 612 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7-1-1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1-1-1920, to 7-1-1920, that I saw him alive on 6-20-1920 and that death occurred, on the date stated above, at 8:20 p.m.

The CAUSE OF DEATH* was as follows:

Severe gangrene of both feet
(Duration) 7 yrs. mos. ds.
CONTRIBUTORY Septic Infection
(Secondary) (Duration) 1 yrs. mos. ds.
(Signed) S. Dumas M. D.
7-3-1920 (Address) 1154 F. Lindbergh

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem DATE OF BURIAL, 7-3-1920

20-UNDERTAKER, Robt Brooks Esq ADDRESS 17 S Calhoun St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificate.

D.44464

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.44464

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 Druid Hill Ave ST. 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Caroline Augusta Bliss*

(Residence in Baltimore: No. 1006 Druid Hill Ave St. 20 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *Wid.*

6-DATE OF BIRTH,

Sept 15, 1852
(Month) (Day) (Year)

7-AGE,

68 yrs. *9* mos. ds.If LESS than 1 day,
...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work. *Housewife*
(b) General nature of industry, business,
or establishment in which
employed (or employer)9-BIRTHPLACE,
(State or Country),*Germany*10-NAME OF
FATHER, *John D. Hinsky*11-BIRTHPLACE
OF FATHER
(State or Country), *Germany*12-MAIDEN NAME
OF MOTHER *Unknown*13-BIRTHPLACE
OF MOTHER
(State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank Bliss*(Address) *1106 Druid Hill Ave*

15-

Robert P. Harrison,

JUL 2 1920

Burial Permit *Clara*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 1, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 25, 1920, to July 1, 1920,*that I saw her alive on *June 30, 1920,*and that death occurred, on the date stated above, at *4:55 am.*

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary) *Apoplexy*

(Duration) ... yrs. ... mos. ... ds.

(Signed) *P. M. Harrison* M. D.*July 1, 1920* (Address) *826 N. Carrollton**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... State ... yrs. ... mos. ... ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cemetery

DATE OF BURIAL,

July 3, 1920

20-UNDERTAKER

Robert Brooks & Son

ADDRESS

17 S Calhoun St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. *Johna Hopkins Hosp.*WARD) *7*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elizabeth Heigl

(a) RESIDENCE. NO.

Kersey, Pa

ST.,

WARD. *Kersey, Penna*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Joseph Heigl*

6 DATE OF BIRTH (month, day, and year)

Nov 14 - 1872

7 AGE

47

Years

7

Months

17

Days

If LESS than
1 day, ____ hrs.
or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Pa*

10 NAME OF FATHER

*Adam Miller*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Germany*

12 MAIDEN NAME OF MOTHER

*Katherine Uhl*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Germany*

14

Informant
(Address)*Hospital Record
J. H. H.*

15

Filed

2 - 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 1 1920

17

I HEREBY CERTIFY, That I attended deceased from

*June 21, 1920, to July 1, 1920*that I last saw her alive on *July 1, 1920*and that death occurred, on the date stated above, at *4:30 P. M.*

The CAUSE OF DEATH* was as follows:

*Pulmonary Infarct acute (left)*CONTRIBUTORY
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *Yes* Date of *June 30 - 20*Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Dr. H. H. H.* M. D.(Address) *Johna Hopkins Hospital*

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St Mary Pa**July 3 1920*

20 UNDERTAKER

ADDRESS

*Joseph Abrams**221 N. Blvd*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 2 - 1920

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.44466

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.44466

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Filed

JUL 2 - 1920

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Heat Stroke

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) JAMES M. BROWN M. D.

(Coroner.) July 22, 1920 (Address) 100 E. CHASE

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH CARE, AND IN INK. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D. 44467 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Jenkins(a) RESIDENCE. NO. 1522 E. Monument St. ST. WARD. Phila., Pa.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bella Jenkins

6 DATE OF BIRTH (month, day, and year)	1894 6 mo
7 AGE	Years Months Days
26	

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) (State or country) Georgia10 NAME OF FATHER John Jenkins11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia12 MAIDEN NAME OF MOTHER Maggie Jannes13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia14 Informant Hospital Records (Address) M.T.H.15 Filled Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 19 2017 I HEREBY CERTIFY, That I attended deceased from June 12, 19 20, to July 1, 19 20,that I last saw him alive on June 30, 19 20,and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date of Was there an autopsy? What test confirmed diagnosis? (Signed) George W. Wilkerson M. D.7-1-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Rice Lough J. A.July 4 1920

20 UNDERTAKER

ADDRESS 1725Mrs. Rolt a. Elliott

JUL 3-1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *320 Palustr*ST.: *20* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Ellen Batterton*(a) RESIDENCE. NO. *320 Palustr*

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *7 1/2* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *July 2 1920*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or 5 min.*✓**✓**✓*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore Md.*10 NAME OF FATHER *William Henry Batterton*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Adm. Ann. del. County*12 MAIDEN NAME OF MOTHER *Sullivan Marie Hard*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md.

14

Informant
(Address)*William Henry Batterton
320 Palustr St Baltimore*

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 2 - 1920*

17

I HEREBY CERTIFY, That I attended deceased from

July 2, 19*20*, to *July 2*, 19*20*,
that I last saw her alive on *July 2*, 19*20*,and that death occurred, on the date stated above, at *11:50 a. m.*

The CAUSE OF DEATH* was as follows:

Ironie blow from of foramen or alk

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Thomas Nelson* M. D.19 (Address) *1001 N. Fulton Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Woodlawn**July 3 1920*

20 UNDERTAKER

ADDRESS

Chenoweth Son Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PIN STEEL should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact Statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 3 - 1920

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.44469

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.44469

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. South Baltimore General Hospital 25 WARD)

2-FULL NAME (Albert) Vajtech Yirka.

(Residence in Baltimore: No. 1120 Pennington Ave. Curtis Bay. St.; yrs. 30 mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married. (Write the word.)

6-DATE OF BIRTH, April 19th. 1869. (Month) (Day) (Year)

7-AGE, 51 yrs. 2 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, City garbage cart driver. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Bohemia.

10-NAME OF FATHER, John Yirka.

11-BIRTHPLACE OF FATHER, (State or Country), Bohemia.

12-MAIDEN NAME OF MOTHER, Catherine Hanzlik.

13-BIRTHPLACE OF MOTHER, (State or Country), Bohemia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Yirka. (son)

(Address) 1120 Pennington Ave.

15-

Robert P. Harrison,

JUL 8 - 1920

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 1st. 1920, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage. Accidentally run over by his cart. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signature) Otto M. Reinhardt M. D. (Coroner) July 2nd 1920 (Address) 1917 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Patapsco Ave. & 7th St. Brooklyn.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Cedar Hill July 3, 1920

20-UNDERTAKER, ADDRESS, East Grackdon 1906 East Blvd.

D.44470

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.44470

40✓

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1251 Decker Ave ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Barbara Fabula

(a) RESIDENCE. No.

1251 Decker Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Andy Fabula

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE 57 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Austria

10 NAME OF FATHER

Joseph Biria

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Czechia

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Austria

14

Informant (Address)

Andy Fabula 1251 Decker Ave, Baltimore.

Robert I. Harrison

JUL 3 - 1920

19

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1920

17

I HEREBY CERTIFY, That I attended deceased from

6-10 1920, to 7-2 1920

that I last saw him alive on 7-1 1920

and that death occurred, on the date stated above, at 1204 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver (Clinical diagnosis)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

Acute Cardiac Dilatation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

if not at place of death?

unknown

Did an operation precede death? 20. Date of

Was there an autopsy? 20

What test confirmed diagnosis?

Findings

(Signed) J. Harrison, M. D.

7-2 1920 Address)

800 N. Patterson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

July 5 1920

20 UNDERTAKER

Frank Brachman

ADDRESS

1906 Ashland Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *John Hopkins Hosp* ST. *10* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Beverly Smith*(a) RESIDENCE. NO. *718 N. Elm St.* ST. *10* WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of *Elizabeth Smith*

(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *unknown*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Virginia*

(State or country)

10 NAME OF FATHER *Chas. Smith*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER *Lee Lillian*13 BIRTHPLACE OF MOTHER (city or town) *va*

(State or country)

14

Informant *Hospital Record*(Address) *J. H. H.*

15

Filed

JUL 3 - 1920

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 2 1920*

17

I HEREBY CERTIFY, That I attended deceased from

July 1, 19*20*, to *July 2*, 19*20*,that I last saw him alive on *July 2*, 19*20*,and that death occurred, on the date stated above, at *5 30 a.* m.

The CAUSE OF DEATH* was as follows:

*Peritonitis Appendicitis**About 1 week*

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *Yes* Date of *July 1st.*Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Edward A. Harrison Jr.*, M. D., 19 (Address) *John Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Winton Park va**July 3 1920*

20 UNDERTAKER

Chas. A. Bailey

ADDRESS

Jefferson St

D. 44472

HEALTH DEPARTMENT--CITY OF BALTIMORE

D. 44472

CERTIFICATE OF DEATH

104

1 PLACE OF DEATH

REGISTERED NO. C.

CITY OF BALTIMORE: (No. 255 E Hamburg St. 24 WARD)

2-FULL NAME George Hopkins Sanderly

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 255 E. Hamburg St. yrs. 6 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Single

6-DATE OF BIRTH

See

18

1919

(Month)

(Day)

(Year)

7-AGE

If LESS than

1 day, hrs.

yrs. 6 mos. 14 ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE
(State or country)

Baltimore Md.

10-NAME OF FATHER

George Henry Sanderly

11-BIRTHPLACE OF FATHER
(State or country)

Roanoke Va.

12-MAIDEN NAME OF MOTHER

Mary Sue Sumner

13-BIRTHPLACE OF MOTHER
(State or country)

Christiansburg Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George H. Sanderly

(Address)

255 E. Hamburg St.

15-

Robert P. Harrison,

JUL 3 - 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July

3

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1, 1920, to, July 2, 1920,

that I saw him alive on July 2, 1920,

and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration)

yrs.

mos.

ds.

Contributory
(SECONDARY)

Feeding

(Duration)

yrs.

mos.

ds.

(Signed),

C. H. Harrison

M. D.

July 3, 1920 [Address] 125 E. Hamburg St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Christiansburg Va.

July 3rd 1920

20-UNDERTAKER

ADDRESS

Wendell Pippel & Son 37 S. Ann St.

Information should be stated EXACTLY. OCCUPATIONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19-H. P. Co.—1000 Hks.

D.44473 HEALTH DEPARTMENT—CITY OF BALTIMORE

D.44473

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Inez Hostt* ST. *2* WARD)

2-FULL NAME

Gilmore (William P.)

(a) RESIDENCE. NO.

2009 Fleet

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

12 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Margaret Gilmore

6 DATE OF BIRTH (month, day, and year)

June 29-1870

7 AGE

48

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

John Gilmore

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Catharine Neys

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Margaret Gilmore 2009 Fleet St

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

6/30/20

17

I HEREBY CERTIFY, That I attended deceased from

July 14 19 *20* to *6/30/20* 19 *20* that last saw him alive on *6/30/20* 19 *20*

and that death occurred, on the date stated above, at *8 40* m.

The CAUSE OF DEATH* was as follows:

Gastric Cancer

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *6/17/20*

Was there an autopsy? *no*

What test confirmed diagnosis? *Laparotomy*

(Signed) *Robert P. Harrison* M. D.

, 19 (Address) *Mary 1st St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Sacred Heart Cemetery 7/3/20

20 UNDERTAKER

ADDRESS

J. G. Moran E. Balt

Burial Permit Clerk.

D. 44474

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44474

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2103 E. Lombard St.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John George Ferber

(a) RESIDENCE.

No. 2103 E. Lombard St.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 65 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Iva Ferber

6 DATE OF BIRTH (month, day, and year)

Dec 19, 1839

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

80

6

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant

Iva Schneider

(Address)

2103 E. Lombard St.

15

Filed

19

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 1 1920

17

I HEREBY CERTIFY, That I attended deceased from

Feb 20, 1920, to July 1, 1920,

that I last saw him alive on July 1, 1920,

and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Arthur Scheraga

(duration) ? yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ? yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) B. Scheraga, M. D.

19 (Address)

100 N. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Carmel Cemetery July 3 1920

20 UNDERTAKER

H. Sander & Son

1710 Fleet St.

JUL 3 1920

Burial Permit Clerk.

PHYSICIAN should state EXACTLY how death should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIAN should state EXACTLY statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 4-9-19-H. P. Co.—1000 Hks.

D.44475

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.44475

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3412 E. Lombard ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Minnie Horr

(a) RESIDENCE. NO. 3412 E. Lombard ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Horr

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1858

7 AGE Years 65 Months 6 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Jacob Holb

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant Emma Phis (Address) 3412 E. Lombard St

15 Filled 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 19 20

17 I HEREBY CERTIFY, that I attended deceased from June 1, 19 20 to June 30, 19 20 that I last saw her alive on June 30, 19 20 and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John S. Owen M.D.

(Address) Farmers & Potomac

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Oak Lawn Cemetery July 5 19 20

20 UNDERTAKER ADDRESS

H. Sander & Son 1710 Fleet St

Burial Permit Clerk.

JUL 2 - 1920

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1807 S. Charles ST.: 12 WARD)

2-FULL NAME

Florence O. Duckett

(a) RESIDENCE. NO. 1807 S. Charles ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 10 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 20 - 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

5

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Charles Duckett

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

12 MAIDEN NAME OF MOTHER

Lora Slagle

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Charles Duckett
1807 S. Charles St.

15

Filed

Robert P. Harrison

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 1 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 29, 1920, to July 1, 1920.

that I last saw him alive on July 1, 1920.

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* as follows:

Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 2 ds.

(duration) yrs. mos. ds. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chilled

(Signed) J. Harrison M. D.

(Address) 1 E. Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill Cemetery July 2 1920

20 UNDERTAKER

ADDRESS

F. A. Krause & Son 703 Hanover

JUL 3 - 1920

Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

0.44477 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.44477

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1622 Druid Hill Ave St. 14 WARD)

2-FULL NAME

Mary Robinson

(Residence in Baltimore: No. 1622 Druid Hill Ave

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 15 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female 4-COLOR OR RACE. Black 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. widowed (Write the word.)

6-DATE OF BIRTH. unknown, 1835 (Month) (Day) (Year)

7-AGE. 85 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Summertime Old Ladies Home (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Delaware

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Brown

(Address) 1622 Druid Hill Ave

15-

Filed 3-1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 1, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry. thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

organic heart disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) atherosclerosis

(Duration) 3 yrs. mos. ds.

(Signed) J. H. Hennessy M. D. (Coroner.)

July 1, 1920 (Address) 2802 Edgewood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). M. E. Home foraged

At place In the of death 15 yrs. mos. ds. State 15 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Delaware

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Mount Auburn Cemetery July 3, 1920

20-UNDERTAKER, ADDRESS John H. Toddman 1622 full st

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.44478

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.44478

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

822 Whatcoat

ST.:

16

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

George Carnegie

(Residence in Baltimore: No.

822 Whatcoat St.

30 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

widow

6-DATE OF BIRTH,

Jan 23, 1872 (Month) (Day) (Year)

7-AGE,

48 yrs. 5 mos. 9 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

Day laborer

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Vincent Carnegie

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Hester Murray

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Virginia Matthews

(Address)

822 Whatcoat St.

15-

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 2, 1920 (Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septic heart disease

(Duration) yrs. mos. ds.

Probably typhoid fever

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Heiney, M. D. (Coroner.)

July 2, 1920 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Anselm

DATE OF BURIAL, July 3, 1920

20-UNDERTAKER

Sam'l McChase 1400 Mosler

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1038 Greenmount ST.; 15th WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1038 Greenmount St.; Life yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word)Single

6-DATE OF BIRTH,

June 24, 1920
(Month) (Day) (Year)

7-AGE,

8 yrs., 0 mos., 0 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).None9-BIRTHPLACE,
(State or Country),Baltimore

PARENTS.

10-NAME OF FATHER,

Hugh Clippinger11-BIRTHPLACE OF FATHER
(State or Country),W Virginia

12-MAIDEN NAME OF MOTHER

Bulah Schenck13-BIRTHPLACE OF MOTHER
(State or Country),Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hugh Clippinger(Address) 1038 Greenmount

2-1920 Robert P. Harrison,

101

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 2, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 27, 1920, to July 2, 1920, that I saw her alive on July 2, 1920, and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

General debility due to premature labor(Duration) 8 yrs., 0 mos., 0 ds.CONTRIBUTORY
(Secondary)Hemorrhage (Duration) 1 yrs., 0 mos., 0 ds.

(Signed)

James M. Wilson M. D.
July 2, 1920 (Address) 200 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Trinity Cemetery

DATE OF BURIAL,

July 3, 1920

20-UNDERTAKER

William Cook

ADDRESS

502 S. North Ave.

B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44480

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Womans Hospital* ST. *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Larise H. Alden*(Residence in Baltimore: No. *Womans Hospital* St.; yrs. *1* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-~~SINGLE~~, MARRIED, *Mar.* WIDOWED, OR DIVORCED (Write the word.)

6-DATE OF BIRTH, *Feb.* *26*, 18*61*
(Month) (Day) (Year)

7-AGE, *59* yrs. *4* mos. *1* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Lady*
(b) General nature of industry, business, or establishment in which employed (or employer). *at home*

9-BIRTHPLACE, (State or Country), *New York*

10-NAME OF FATHER, *J. B. Spader*
11-BIRTHPLACE OF FATHER (State or Country), *New York*
12-MAIDEN NAME OF MOTHER, *M. R. Hammond*
13-BIRTHPLACE OF MOTHER (State or Country), *New York*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harry H. Clemens*(Address) *Etie City Pa.*

15-

JUL 8 - 1920

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July* *2*, 19*20*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *June 12* 19*20*, to *July 2* 19*20*, that I saw her alive on *July 2* 19*20*, and that death occurred, on the date stated above, at *2:00* A.M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

(Duration) *2?* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Operation of Pneumonia*
(Duration) yrs. mos. ds.

(Signed) *James S. Spader* M. D.
July 2, 1920 (Address) *Womans Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. *20* ds. In the State yrs. mos. *20* ds.

Where was disease contracted, if not at place of death? *?*

Former or usual residence *Etie Pa*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Etie City Pa. *July 8, 1920*

20-UNDERTAKER ADDRESS

Henry W. Harrison Sons Co. Baltimore

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION is very important. See instructions on back of certificate.

D.44481 HEALTH DEPARTMENT—CITY OF BALTIMORE D.44481

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 433 E. Sanvale ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Bessie Virginia Coffay

(Residence in Baltimore: No. 433 E. Sanvale ST. St.; 23 yrs., 11 mos., 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

July 11, 1896
(Month) (Day) (Year)

7-AGE,

23 yrs., 11 mos., 19 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).House wife
6379-BIRTHPLACE,
(State or Country),

Baltimore Md.

10-NAME OF FATHER,

Edward McKnew

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore Md

12-MAIDEN NAME OF MOTHER

Bessie V. Brown

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

James E. Coffay
(Address) 433 E. Sanvale St.

15-

JUL 13 1920 Robert P. Harrison,

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 1, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 1919, to July 1, 1920, that I saw her alive on July 1, 1920, and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Tuberculosis
from history
(Duration) 6 yrs., 11 mos., 19 ds.CONTRIBUTORY
(Secondary)(Signed) J. H. Gushane, M. D.
July 3, 1920 (Address) 3100 Harford St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Cathedral

July 5, 1920

20-UNDERTAKER

ADDRESS

E. A. Miedefeld

Baltimore

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL CONDITION should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 44482

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44482

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 Russell ST.; 21 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Anelia Ernst(Residence in Baltimore: No. 912 Russell

St.; yrs. mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Wht5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

June 15, 1854
(Month) (Day) (Year)

7-AGE,

46 yrs. 0 mos. 16 ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore Md

10-NAME OF FATHER,

Mr. P. M. Ernst

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Wilhelmine Kahrzang

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. F. Ernst(Address) 912 Russell St

15-

JUL 3 - '1920

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 14, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Feb - 1920, to June 30 1920, that I saw her alive on June 30 1920, and that death occurred, on the date stated above, at 5 P. m. The CAUSE OF DEATH* was as follows:Pulmonary tuberculosis(Duration) 6 yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) 14 yrs. 14 mos. 14 ds.(Signed) Edw. Harrison M. D.July 3, 1920 (Address) 517 East 12

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cem

DATE OF BURIAL,

7/1/20, 191...

20-UNDERTAKER

F. B. Wipperfurth

ADDRESS

2336 Frederick Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Ills.

0.44483 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.44483
105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 842 S. Bond. ST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 842 S. Bond ST. WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year) Dec 4 - 1916

7 AGE Years 3 Months 6 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

" "

(c) Name of employer

" "

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER Antoni Sobotta

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER Stanislaw Krozko

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14 Informant (Address) St. Krozko 842 S. Bond St.

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1920

17 I HEREBY CERTIFY, That I attended deceased from

June 28, 1920, to July 2, 1920,

that I last saw him alive on July 2, 1920,

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Illegitimate

(duration) yrs. mos. ds. 8 CONTRIBUTORY Cardiac Exhaustion (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William G. Brown M. D.

(Address) 801 N. Lee Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Rosary 9/3 1920

20 ADDRESS

1618 Eastern

JUL 3 - 1920

Burial Permit Clerk

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 44484 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 44484

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 619 S. Sharp St.

ST.

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pearl Rainey. (C)

(Residence in Baltimore: No. 619 S. Sharp St.

St. yrs. 2 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female.

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single.

6-DATE OF BIRTH,

April 9th. 1920.

(Month)

(Day)

(Year)

7-AGE,

2 yrs. 22 mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None.

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Samuel Rainey. (C)

11-BIRTHPLACE OF FATHER

(State or Country),

South Carolina.

12-MAIDEN NAME OF MOTHER

Harriet Daniels. (C)

13-BIRTHPLACE OF MOTHER

(State or Country),

Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harriet Rainey. (C) mother.

(Address) 619 S. Sharp St.

15-

Robert P. Harrison,

July 3 - 1920 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 1st. 1920.

(Month)

(Day)

191...

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Whooping Cough.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed)

July 1st. 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE *D. 44485*

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *708 D. N. Ave.* ST. *17* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *708 D. N. Ave.* St. *7* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

1867 (Month) *1* (Day) (Year)

7-AGE

52 yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert P. Harrison*(Address) *708 D. N. Ave.*

15-

JUL 3 1920 *Robert P. Harrison* Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 18 191*20* (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on *June 30* 191*20*and that death occurred, on the date stated above, at *8 A.M.*

The CAUSE OF DEATH* was as follows:

Arterial Hypertension(Duration) *3* yrs. mos. ds.CONTRIBUTOR (Secondary) *Arterial Hypertension*(Duration) *7* yrs. mos. ds.(Signed) *A. R. Harrison* M. D.*7/21* 191*20* (Address) *724 Maple*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *7* yrs. mos. ds. In the State *7* yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Laurel Cem. *July 21* 191*20*

20-UNDERTAKER

ADDRESS

Samuel Gensley *578*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 W. 24th ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and put out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 117 W. 24th St.; 60 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-STATUS,
~~Married~~,
WIDOWED,
OR DIVORCED,
(Write the word.)Widowed

6-DATE OF BIRTH,

Jan 17th, 1834
(Month) (Day) (Year)

7-AGE,

86 yrs. 5 mos. 14 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Real Estate
Business9-BIRTHPLACE.
(State or Country),Penn

10-NAME OF FATHER,

Jacob Eppley

11-BIRTHPLACE OF FATHER

(State or Country),

Penn

12-MAIDEN NAME OF MOTHER

Jane McGrew

13-BIRTHPLACE OF MOTHER

(State or Country),

Penn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. P. A. Seibert

(Address)

117 W. 24th St

15-

Filed 3-19-20 Robert P. Harrison,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 1st, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 30th 1920, to July 1st 1920,that I saw him alive on July 1st 1920,and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis(Duration) 3 yrs. — mos. — ds.CONTRIBUTORY
(Secondary)(Duration) 3 yrs. — mos. — ds.

(Signed)

Eugene Douglas M. D.
July 1st, 1920 (Address) 830 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

David Ridge July 2nd, 1920

20-UNDERTAKER

ADDRESS

John Ostutell 1301 N. Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 44487

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44487

CERTIFICATE OF DEATH.

X 174 ✓

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Thurs. Hosp.*

ST.: *9*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Albert F. Frimer

(a) RESIDENCE. No. *916 E. Pratt*

(Usual place of abode)

ST.,

WARD.

England

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

ys. *6* mos.

ds. How long in U. S., if of foreign birth?

ys. *6* mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Emma Frimer

6 DATE OF BIRTH (month, day, and year)

7/18/76

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

43

11

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labourer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

England

10 NAME OF FATHER

John Frimer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Engl.

12 MAIDEN NAME OF MOTHER

Anna Daley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Engl.

14

Informant (Address)

Fred Frimer 916 E. Pratt St.

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

7/1

19 *20*

17

I HEREBY CERTIFY, That I attended deceased from

6/28, 19 *20*, to *7/1*, 19 *20*.

that I last saw him alive on

7/1, 19 *20*.

and that death occurred, on the date stated above, at

11 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Cyst - Nature & duration determined.

(duration) *2* yrs. *6* mos. *1* da.

CONTRIBUTORY (Secondary)

Surgical Shock

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Yes Date of *7/1*

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

Lucius D. Ridgeley

M. D.

7/1, 19 *20* (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Balto. Cemetery

July 5, 1920

20 UNDERTAKER

ADDRESS

S. Hinson & Bro E Balto St

D. 44488 HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44488

CERTIFICATE OF DEATH.

30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

763 W Saratoga

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Alberta Minners

(a) RESIDENCE. NO.

763 W Saratoga

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 2 1920

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to July 2, 1920, that I last saw her alive on July 2, 1920, and that death occurred, on the date stated above, at 6:55 p. m.

The CAUSE OF DEATH* was as follows:

Meningitis (Tubercular)

(duration)

yrs.

mos.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test caused diagnosis?

(Signed)

, 19 (Address)

M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

3 JUL 3 1920

Robert P. Harrison,

Registrar

mt Auburn July 3 1920
 L J Brownson 108 morth

D.44489

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.44489

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Baltimore Hosp

REGISTERED No. C

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Am E Gambrie

(Residence in Baltimore: No.

633 W Balt St

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

March 17, 1862 (Month) (Day) (Year)

7-AGE,

58 yrs., 13 mos., 14 ds.

IF LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Foreman 086
Text. Factory

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

John Gambrie

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER,

Gerina Michael

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Emma Gambrie

(Address) 633 W Balt St

15-

Robert P. Harrison,

191

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 1, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1, 1920, to July 1, 1920,

that I saw him alive on July 1, 1920,

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Bright's disease

uræmic coma

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

uræmic coma

(Duration) yrs. mos. ds.

(Signed) J. J. J.

July 2, 1920 (Address) Baltimore Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Not known

Former or usual residence 633 W Balt St

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Baltimore Md 7/3, 1920

20-UNDERTAKER ADDRESS

George A. J. J.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE YEARLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

44490
44488

HEALTH DEPARTMENT—CITY OF BALTIMORE

44490

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital*
CITY OF BALTIMORE (No. *175-001* ST.: WARD) REGISTERED No. C
2-FULL NAME *Dr. H. Luster*
(Residence in Baltimore: No. *Reese Md* St.: yrs. mos. / ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*
4-COLOR OR RACE, *White*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)
6-DATE OF BIRTH, *1870*
(Month) (Day) (Year)

7-AGE, *Abrah 50* yrs. mos. ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Tanner*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *Not known*

11-BIRTHPLACE OF FATHER (State or Country), *Maryland*

12-MAIDEN NAME OF MOTHER *Not known*

13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. D. H. Luster*

(Address) *Reese Md.*

15- *Robert P. Harrison,*

Filed *1320*, 191. Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 3, 1940*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an. (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said. (Inquest or autopsy.)

And that said deceased came to death today or inquiry.)

On the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage & Shock

(Duration) yrs. mos. ds. *4 hours*

CONTRIBUTORY (Secondary) *is Auto Accident*

(Duration) yrs. mos. ds. *4 hours*

(Signed) *H. K. Jones* M. D. (Coroner.)

7.3.1940 (Address) *7.3.1940*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. / ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence *Reese Md.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Johns Lutheran Cemetery July 5, 1940

20-UNDERTAKER, ADDRESS *235 GREEN ST*

H. W. Roush Baltimore Md.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1036 Hollins*)ST.: *18* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *John C. Bilson*(a) RESIDENCE. NO. *1036 Hollins*
(Usual place of abode)

ST., WARD.

Length of residence in city or town where death occurred *2* yrs. mos. ds. How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct. 9, 1888*7 AGE Years *31* Months *8* Days *21* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Painter*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Hayward + Winfield*9 BIRTHPLACE (city or town) *Balto*
(State or country)10 NAME OF FATHER *Jos. C. Bilson*11 BIRTHPLACE OF FATHER (city or town) *Ms.*
(State or country)12 MAIDEN NAME OF MOTHER *Mary Chapman*13 BIRTHPLACE OF MOTHER (city or town) *Balto*
(State or country)14 Informant *William R. Bilson*
(Address) *1036 Hollins Street*15 Filed *Robert P. Harrison,*
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *7/1/20* 1917 I HEREBY CERTIFY, That I attended deceased from *3/19/20*, 19, to *6/30/20* *7/1/20*, 19,that I last saw him alive on *6/30/20*, 19,and that death occurred, on the date stated above, at *8 A.* m.

The CAUSE OF DEATH* was as follows:

Pul. Phthisis(duration) *4* yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *h* Date ofWas there an autopsy? *h*What test confirmed diagnosis? *Specimen*(Signed) *Bernard J. Jany*, M. D.*7/1*, 19*20* (Address) *910 W Lombard*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**July 5 - 1920*

20 UNDERTAKER

ADDRESS

*William Cook**503 E. North Ave*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 4 - 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1333 Myrtle St. WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 1333 Myrtle St. 20 yrs., 17 mos., 17 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Caucasian

5-SINGLE

MARRIED
WIDOWED
OR DIVORCED
(Write the word.)

6-DATE OF BIRTH,

1838

(Month)

(Day)

(Year)

7-AGE,

78

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Mariner
Boatman9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

Robert Brown

11-BIRTHPLACE OF FATHER
(State or Country),

Pa

12-MAIDEN NAME OF MOTHER

Julia Brown

13-BIRTHPLACE OF MOTHER
(State or Country),

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

June 30th, 1920
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from Jan 18th 1920, to June 30th 1920, that I saw him alive on May 30th 1920, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Heart Failure

Duration... yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Signed) J. L. Harrison M. D.

724 Myrtle St., 1912. (Address) 724 Myrtle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laurel Cemetery July 4th, 1920

20-UNDERTAKER

ADDRESS

John H. Toddman 1424 Hill St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUL 4 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE,

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (N. 1923 Division ST. 14 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1923 Division St.; 2 yrs., 4 mos. - ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Cov

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Aug 1, 1917

(Month)

(Day)

(Year)

7-AGE,

2 yrs., 11 mos., ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Child

9-BIRTHPLACE,
(State or Country),

N. J.

10-NAME OF FATHER,

Daniel L. Baynham

11-BIRTHPLACE OF FATHER
(State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Ellen Crowell

13-BIRTHPLACE OF MOTHER
(State or Country),

N. J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

A. L. Baynham
1923 Division St.

15-

Robert P. Harrison,

Filed.....

191

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 2, 1922

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to July 2, 1922, that I saw him alive on July 2, 1922, and that death occurred, on the date stated above, at 7:00 p.m.

The CAUSE OF DEATH* was as follows:

Asphyxiation by strangulation

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) W. J. Coleman M. D.

July 2, 1922 (Address) 703 N. Beach

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn

DATE OF BURIAL,

July 3, 1922

20-UNDERTAKER

JAMES H. DENNIS

ADDRESS

1303 PRESTMAN ST.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

10.44494 HEALTH DEPARTMENT—CITY OF BALTIMORE

10.44494

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1504 n chapel, St. 8

2-FULL NAME

Robert Douglas Jr

(Residence in Baltimore: No. 1504 n chapel, St. yrs. / mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, wh 5-SINGLE, MARRIED, Widowed, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, May 16, 1920 (Month) (Day) (Year)

7-AGE, If LESS than 1 day, yrs. 1 mos. ds. hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, child (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), MD

10-NAME OF FATHER, Robert Douglas

11-BIRTHPLACE OF FATHER (State or Country), MD

12-MAIDEN NAME OF MOTHER, Caroline Huber

13-BIRTHPLACE OF MOTHER (State or Country), MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Douglas

(Address) 1504 Chapel St

15- Robert P. Harrison, 101

Filed 1920 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 2, 1920 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained held an Inquest, au-

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) M. D. (Coroner) 1504 Chapel St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St Marys Hampden July 4 1920

20-UNDERTAKER ADDRESS

Chenoweth & Co

D. 44495 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 44495

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Millman ST. WARD 2)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1606 Millman St. 8 yrs. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Fem.

4-COLOR OR RACE.

Colored

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

S

6-DATE OF BIRTH

June 16, 1912
(Month) (Day) (Year)

7-AGE.

8 yrs. 14 ds.

If LESS than 1 day,
....hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, business,
or establishment in which
employed (or employer).9-BIRTHPLACE,
(State or Country).10-NAME OF
FATHER.11-BIRTHPLACE
OF FATHER
(State or Country).12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert P. Harrison,

(Address) 1606 Millman St.

15-

Robert P. Harrison,

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

June 30, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
June 24, 1912, to June 2, 1912,
that I saw him alive on June 30, 1912,
and that death occurred, on the date stated above, at 3:15 p. m.
The CAUSE OF DEATH* was as follows:.....
.....
.....
.....
..... (Duration)..... yrs. mos. ds.CONTRIBUTORY
(Secondary)..... (Duration)..... yrs. mos. ds.
(Signed) J. L. Shelton M. D.
....., 1912 (Address) 203 W. ...*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Mt. Zion Cem. July 1, 1920

20-UNDERTAKER ADDRESS

Mrs. G. Locks 1302 ...

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C. *92*

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Memorial Hospital* ST.; *15* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1907 Herbert St.* St.; *12* yrs., *12* mos., *12* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH.

March 15, 1879
(Month) (Day) (Year)

7-AGE.

41 yrs., *3* mos., *18* ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Shoe maker*

9-BIRTHPLACE, (State or Country).

Poland

10-NAME OF FATHER.

Abraham Cohen

11-BIRTHPLACE OF FATHER (State or Country).

Poland

12-MAIDEN NAME OF MOTHER

Sherry

13-BIRTHPLACE OF MOTHER (State or Country).

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Geo. E. W. Hardy, Jr.*(Address) *Union Memorial Hospital*

15-

JUL 4 - 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 3, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 1, 1920*, to *July 3, 1920*, that I saw him alive on *July 3, 1920*, and that death occurred, on the date stated above, at *6.10 a.m.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary)

Acute dilatation of heart
less than one hour

(Signed)

Geo. E. W. Hardy M. D.
July 3, 1920 (Address) *Union Memorial Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. *3* mos. *3* ds. In the State yrs. *9* mos. *12* ds.Where was disease contracted, if not at place of death? *1907 Herbert St.*Former or usual residence *1907 Herbert St.*

19-PLACE OF BURIAL OR REMOVAL.

Nehalem Washington Rd

DATE OF BURIAL.

July 4, 1920

20-UNDERTAKER

Jack Lewis

ADDRESS

*1411 E. 1st St.*WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph Hosp.* ST.: *9* WARD)

2-FULL NAME *Frank Turan*

(a) RESIDENCE. NO. *St. Joseph's Home* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. mos. ds. How long in U. S., if of foreign birth? *15* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *W.* 5 Single, Married, Widowed, or Divorced (write the word) *Divorced*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE *80* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*

10 NAME OF FATHER *Unknown*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant *St. Joseph Hospital* (Address) *Robert P. Harrison*

15 Filed *1920* Registrar *Burial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 3 1920*

17 I HEREBY CERTIFY, That I attended deceased from *Oct 30*, 19*19*, to *July 3*, 19*20*, that I last saw him alive on *July 3*, 19*20*, and that death occurred, on the date stated above, at *3 4* . m.

The CAUSE OF DEATH* was as follows: *Myocardial Infarct*

(duration) yrs. mos. ds. *3*

CONTRIBUTORY *arterio-sclerosis* (Secondary)

(duration) yrs. mos. ds. *1*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no*. Date of

Was there an autopsy? *no*.

What test confirmed diagnosis?

(Signed) *J. C. Marine* M. D.

7/3/20 19 (Address) *St. Joseph Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer *July 5 1920*

20 UNDERTAKER ADDRESS

Frank A. Kent *915 N. Gay*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20.44498 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.44498

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital ST.: 1 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Margarteha Lucke.
(Residence in Baltimore: No. 26 S. Potomac St. 46 -----
St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female. White. Married
6-DATE OF BIRTH, March 18th. 1848. 1
(Month) (Day) (Year)
7-AGE, 72 yrs. 3 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.
10-NAME OF FATHER, Henry Schubert.
11-BIRTHPLACE OF FATHER (State or Country), Germany.
12-MAIDEN NAME OF MOTHER Do not know.
13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Anna E. Weide. (daughter) ...
(Address) 26 S. Potomac St.

15-
Filed 4-1920 Robert P. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 1st. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the Skull.
Accidentally struck by car #1161 of U. R. Y. & E. Co. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ...
(Signature) ...
(Coroner) ...
July 2nd 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death? ...
15th. & O'Donnell Sts.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Mathews Cemetery July 4, 1920

20-UNDERTAKER, ADDRESS

Philip Herwig Orleans

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 Laurens ST.: 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Morton(Residence in Baltimore: No. 1808 Laurens St.: 30 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

June 3, 1853
(Month) (Day) (Year)

7-AGE,

67 yrs., 1 mon., ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Postman

9-BIRTHPLACE, (State or Country),

Virginia

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence Morton(Address) 1808 Laurens St.

15-

Filed, 1920, 2, 191.....

Robert P. Harrison,

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 2, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Feb. 15 1919, to July 2 1920, that I saw him alive on July 2 1920, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease(Duration) 1 yrs., 5 mos., ds.CONTRIBUTORY (Secondary) Paralysis following apoplexy(Duration) 1 yrs., 2 mos., ds.(Signed) John D. Harrison M. D.July 3, 1920 (Address) 1507 N. Fulton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Peters

DATE OF BURIAL,

July 4, 1920

20-UNDERTAKER

Samuel Wright 1364 Carey

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 44500

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44500
120 ✓

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO *Franklin D. Hospital* ST.: *9* WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *2710 Hugo Av.* ST.: *WARD.*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *10* mos. ds. How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word) *Single*

5a If married, widowed, or divorced *daughter of* HUSBAND of *Mrs. Franziska Scharper* (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1888*

7 AGE Years *32* Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *clerk*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *U. S. Treasurer Dept*

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *md*

10 NAME OF FATHER *John E. Scharper*

11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)

12 MAIDEN NAME OF MOTHER *Franziska Bartell*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *Maryland*

14 Informant *John H. Lealle* (Address) *269 Ramoey St*

15 Filed *Robert P. Harrison,* Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *7/2 - 1920*

17 I HEREBY CERTIFY, That I attended deceased from *June 22, 1920*, to *July 2, 1920*, that I last saw *her* alive on *July 2, 1920*, and that death occurred, on the date stated above, at *12:00 P. M.*

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Herbert J. Parr*, M. D.

. 19 (Address) *Franklin D. Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Louisa Park Cmr

20 UNDERTAKER

Henry W. Smith & Son

DATE OF BURIAL

7-6 1920

ADDRESS

Orchard McCallister

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 44501 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 44501

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 Lewis

ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Geraline Bates (Sledge)

(a) RESIDENCE. NO. 413 Lewis

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

1 yrs. 5 mos.

ds.

How long in U. S., if of foreign birth? 15 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Caf

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 19 - 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore
Md

10 NAME OF FATHER

Conrad Sledge

11 BIRTHPLACE OF FATHER (city or town) (State or country)

unknown

12 MAIDEN NAME OF MOTHER

Julia Bates

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

Julia Bates
413 Lewis St

15

Filed

19

Robert B. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 3 19 20

17

I HEREBY CERTIFY, That I attended deceased from

July 3, 19 20, to July 3, 19 20

that I last saw him alive on July 3, 19 20

and that death occurred, on the date stated above, at 7:30 p. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. C. Barnes, M. D.

(Address) 22182 P St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel Cemetery

July 4 19 20

20 UNDERTAKER

ADDRESS

Mrs R. A. Elliott

1725
Ashland

Burial Permit Clerk

1. ~~Sumner~~ Bro Balto at

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 W Lombard ST.; 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1014 W Lombard St.; 40 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) single

6-DATE OF BIRTH,

Aug 28, 1879
(Month) (Day) (Year)

7-AGE,

40 yrs., 10 mos., 5 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....Labeling

9-BIRTHPLACE, (State or Country),

Balto. city old

10-NAME OF FATHER,

Theodore Berry

11-BIRTHPLACE OF FATHER (State or Country),

Not Known

12-MAIDEN NAME OF MOTHER

Not Known

13-BIRTHPLACE OF MOTHER (State or Country),

Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W. Little(Address) 531 N. Fremont

15-

Filed 1920 Robert P. Harrison,
191.....Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 3, 1920.
(Month) (Day) (Year)

17-HEREBY CERTIFY, That I attended deceased from

Oct — 1919, to July 3 1920,that I saw him alive on July 3 1920,and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

asthma
(Duration)..... yrs. mos. 3 ds.

CONTRIBUTORY. (Secondary)

(Duration)..... yrs. mos. ds.
(Signed)..... M. D.7/3, 1920 (Address) 150 27 Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

July 6, 1920

20-UNDERTAKER

Geo W. Little

ADDRESS

531 N. Fremont

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Best statement of OCCUPATION is very important. See instructions on back of certificate.

D.44504 HEALTH DEPARTMENT—CITY OF BALTIMORE **D.44504**

CERTIFICATE OF DEATH

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 409 North Shrewder ST. 18 WARD)

2-FULL NAME Archibald D. Moore

(Residence in Baltimore: No. 409 North Shrewder St. St.; 79 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower (Write the word)

6-DATE OF BIRTH June 14, 1841 (Month) (Day) (Year)

7-AGE 79 yrs. 7 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Retired Stone Merchant (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore Md

10-NAME OF FATHER John Moore

11-BIRTHPLACE OF FATHER (State or country) Baltimore Md

12-MAIDEN NAME OF MOTHER Catharine S. Hedding

13-BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Edgar W. Moore (Address) Kensington, Ind

15. Robert P. Harrison, REGISTRAR
4-1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 3, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1920 to July 3, 1920 that I saw him alive on July 2, 1920 and that death occurred, on the date stated above, at 8:50 p. m. The CAUSE OF DEATH* was as follows:
Cancer of Stomach

(Duration) 3 yrs. 18 mos. 18 ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Henry M. Stevenson M. D. (Address) 1022 West Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or CIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, if not at place of death? _____
Former or usual residence _____

19-PLACE OF BURIAL OR REMOVAL Woodlawn DATE OF BURIAL July 6, 1920

20-UNDERTAKER Geo W Little ADDRESS 531 St Fremont Ave

JUL 4-1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *730 W Lexington* ST.: *4* WARD)2-FULL NAME *Alphonse Macis*(a) RESIDENCE. NO. *730 W Lexington* ST. *4* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *11* mos. *11* ds.How long in U. S., if of foreign birth? *life* yrs. *life* mos. *life* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *11* *21*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None - 000*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto - Maryland*10 NAME OF FATHER *Francis Macis*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Lithuania - Russia*12 MAIDEN NAME OF MOTHER *Elena - Smith*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto - MD*14 Informant (Address) *Alphonse Macis 730 W Lexington*15 Filed *Robert P. Harrison, Registrar*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 3, 1920*17 I HEREBY CERTIFY, That I attended deceased from *July 1, 1920* to *July 3, 1920*, that I last saw him alive on *July 3, 1920*, and that death occurred, on the date stated above, at *5 p - m*. The CAUSE OF DEATH* was as follows:*Cholera infantum*CONTRIBUTORY (Secondary) *Malnutrition* (duration) *5* mos. *30* ds.18 Where was disease contracted if not at place of death? *No*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *W. J. Springer, M.D.*(Address) *1822 Calverton Rd*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Holy Redeemer* DATE OF BURIAL *July 7, 1920*20 UNDERTAKER *John Grelbancas* ADDRESS *425 S. Park St*

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 4 - 1920

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0.44506

HEALTH DEPARTMENT—CITY OF BALTIMORE

0.44506

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *16* ST. *16* WARD)

2-FULL NAME

Mrs. Blanche Brown

(a) RESIDENCE. No. *1302 N. Harlem Ave.* ST. *16* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *58* yrs. *9* mos. *7* ds.

How long in U. S., if of foreign birth? *58* yrs. *9* mos. *7* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of *Thomas S. Brown*

6 DATE OF BIRTH (month, day, and year) *Sept 25 1861*

7 AGE Years *58* Months *9* Days *7* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto. Md.*

10 NAME OF FATHER *Richard Leiby*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*

12 MAIDEN NAME OF MOTHER *Mrs. E. Kolden*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

14 Informant *Mrs. Touch*

(Address) *704 No. Carey Street*

15 Filled *Robert P. Harrison,*

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *7/2* 19*20*

17 I HEREBY CERTIFY, That I attended deceased from *7/1*, 19*20*, to *7/2*, 19*20*, that I last saw him alive on *7/2*, 19*20*, and that death occurred, on the date stated above, at *11.40 a* m. The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(duration) yrs. *5* mos. ds.

CONTRIBUTORY (Secondary) *Cachexia*

(duration) yrs. *2* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *7/1/20*

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Lucius S. Ridgely* M. D.

7/2, 19*20* (Address) *1003 N. Carey St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Greenmount Cemetery*

DATE OF BURIAL *July 5 1920*

20 UNDERTAKER *Joseph B. Cook*

ADDRESS *1003 N. Carey St. Balto*

JUL 4 - 1920

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Donald Cratty
D. 44507 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 44507

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *Hopkins Ward 7*)
2-FULL NAME *Donald Cratty*
(Residence in Baltimore: No. *(Pittman n. va)*)
REGISTERED NO. C
WARD) (If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *S.*
6-DATE OF BIRTH, *Nov. 28, 1901*
(Month) (Day) (Year)

7-AGE, *18 yrs. 5 mos. 6 da.* If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *miner*
(b) General nature of industry, business, or establishment in which employed (or employer) *086*

9-BIRTHPLACE, (State or Country), *Va.*

PARENTS.
10-NAME OF FATHER, *Arthur W. Cratty*
11-BIRTHPLACE OF FATHER (State or Country), *N. Va.*
12-MAIDEN NAME OF MOTHER, *Annie Hale*
13-BIRTHPLACE OF MOTHER (State or Country), *N. Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *John Hopkins Records*
(Address)

15- Robert P. Harrison,
Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *July 3, 1902*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:
Spontaneous, coal
fell on him while
working in mine
(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place In the
of death....yrs....mos....da. State....yrs....mos....da.

Where was disease contracted, if not at place of death?.....
Former or usual residence *Petersburg N. Va.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL
Petersburg N. Va. July 6, 1902

20-UNDERTAKER ADDRESS
H. E. Hughes 17 S. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44508

D. 44508

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; 10 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 1 5 yrs., 5 mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I saw her alive on

and that death occurred, on the date stated above, at 4 8 a.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

Duration yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Duration yrs. mos. ds.

(Signed) F. A. Warner M. D.

July 4, 1920 (Address) 1133 Valley M.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 1 yrs. 5 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Robert P. Harrison,

Burial Permit Clerk

 Cumberland Md July 4, 1920
 R. C. Wiedefeld 914 Greenmount
 an

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.44509

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.44509

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1542 Carey W

ST.: 15 WARD)

REGISTERED NO.

(if death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Eliza Jones

(a) RESIDENCE. NO. 1542 Carey (Usual place of abode)

ST., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ♀ 4 COLOR OR RACE Col. 5 Single, Married, Widowed, or Divorced (Write the word) S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20 - 20

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

10 NAME OF FATHER Jno. Hall

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Pearl M. Jones

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Emma Jones (Address) 1542 Carey W

15 Filed Robert Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/1 1920

17 I HEREBY CERTIFY, That I attended deceased from 6/23, 1920, to 7/1, 1920, that I last saw him alive on 7/1, 1920, and that death occurred, on the date stated above, at 9:55 P. M.

The CAUSE OF DEATH was as follows: Ac. enteritis with bloody stools (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1542 Carey W

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) B. H. Chittenden, M. D.

, 19 (Address) 2139 Oak St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Auburn gale 5-20-19

20 UNDERTAKER ADDRESS

JAMES H. DENNIS

1303 PRESTMAN ST.

JUL 5 - 1920

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PH (Signature) should state CAUSE OF DEATH in plain terms, so that it may be properly classified. In fact statement of OCCUPATION is very important. See instructions on back of certificates.

0.44510 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.44510

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2328 Edmondson Ave ST. 16 WARD)

2-FULL NAME

Clara May Van Newkirk

(a) RESIDENCE. No.

2328 Edmondson Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 15th 1871

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

48

6

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Edward Van Newkirk

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Amanda Kirby

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

John J. Swartzburg 2328 Edmondson Ave

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 2 - 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 27, 1920, to July 2, 1920,

that I last saw him alive on July 2, 1920,

and that death occurred, on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) M. J. M. and Wood, M. D.

July 2, 1920 (Address)

626 N. Gilman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cem

July 5 1920

20 UNDERTAKER

Wm J. Tickner & Sons

ADDRESS

11 Pa

Burial Permit Clerk.]

JUL 5 - 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 W Layale ST.; 17 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 706 W Layale St.; 70 yrs., 7 mos., 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Colored5-SINGLE, married,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

Unknown, 1842
(Month) (Day) (Year)

7-AGE.

78 yrs., — mos., — ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....Wm 037
Wm

9-BIRTHPLACE.

(State or Country), Va

PARENTS.

10-NAME OF
FATHER,Unknown11-BIRTHPLACE
OF FATHER
(State or Country)Va
James Richardson12-MAIDEN NAME
OF MOTHERJames Richardson13-BIRTHPLACE
OF MOTHER
(State or Country),Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nettie Jones(Address) 706 W Layale St.

15-

Filed 3-1920 191 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 2, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 30, 1920, July 2, 1920,
that I saw h or alive on July 1, 1920,and that death occurred, on the date stated above, at 1/4 m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis
Chronic(Duration) 8 yrs., 7 mos., 7 ds.CONTRIBUTORY
(Secondary)(Duration) 8 yrs., 7 mos., 7 ds.(Signed) John C. Stephens M. D.July 4, 1920 (Address) 704 W Layale St.*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-
SIENTS, OR RECENT RESIDENTS).At place of death — yrs., — mos., — ds. In the — yrs., — mos., — ds.Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Auburn City July 5, 1920

20-UNDERTAKER

ADDRESS

Mrs Robt Elliott Asland

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No. 23 ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mrs. Lillie V. Tall

(Residence in Baltimore: No. 23 N. Luzerne AveSt. 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female White

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Married

6-DATE OF BIRTH,

April 25, 1866
(Month) (Day) (Year)

7-AGE,

64 yrs. 2 mos. 8 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Housework
At home9-BIRTHPLACE,
(State or Country),

Penna.

10-NAME OF FATHER,

Mr. Peacock

11-BIRTHPLACE OF FATHER
(State or Country),

Penna.

12-MAIDEN NAME OF MOTHER

Susan Bixler

13-BIRTHPLACE OF MOTHER
(State or Country),

Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joseph W. Tall

(Address)

23 N. Luzerne Ave.

15-

Robert P. Harrison,

Filed

191

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 3, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 25, 1920, to July 3, 1920,
that I saw her alive on July 3, 1920,
and that death occurred, on the date stated above, at 11:10 p. m.

The CAUSE OF DEATH* was as follows:

Cause unknown
probably general septicemia
(Duration) yrs. 2 mos. ds.CONTRIBUTORY
(Secondary)(Signed) Charles S. Levy M. D.
7-3-20 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Bridgeway Cem. July 6, 1920

20-UNDERTAKER

ADDRESS

Wm. B. Black 927 N. Broadway

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-STATUS

MARRIED

WIDOWED

OR-DIVORCED

(Write the word)

6-DATE OF BIRTH

7-AGE

IF LESS than

1 day, 5 hrs.

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15.

Filed

Robert B. Harrison,

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

July 3, 1920, to July 4, 1920.

that I saw him alive on July 3, 1920.

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Lebanese manatonic

Contributory Prominent Rash

(Signed) Geo. F. Taylor M. D.

July 4, 1920. (Address) 1212 N. B'way

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Redeemer

July 5, 1920

20-UNDERTAKER

ADDRESS

Ginkler Ginkler

1739

Eager

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

0.44514 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.44514

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 830 Bradley ST. 17 WARD) (If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Annie Spence
(Residence in Baltimore: No. 830 Bradley St. 7 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female	4-COLOR OR RACE. Black	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single
6-DATE OF BIRTH. Unknown, 1872 (Month) (Day) (Year)		
7-AGE. 48 yrs. mos. ds.		If LESS than 1 day, ...hrs. or...min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Laundress		
9-BIRTHPLACE. (State or Country). Maryland		
PARENTS.	10-NAME OF FATHER. Unknown	
	11-BIRTHPLACE OF FATHER (State or Country). Unknown	
	12-MAIDEN NAME OF MOTHER Unknown	
	13-BIRTHPLACE OF MOTHER (State or Country). Unknown	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel F. Bivert

(Address) 830 Bradley St.

15- Robert P. Harrison,
Filed 1920, 191. Burial Permit 013 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.
July 2, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) yrs. mos. 21 ds.
CONTRIBUTORY (Secondary) no history
(Duration) yrs. mos. ds.
(Signed) J. A. Henderson M. D.
(Coroner.)
July 3, 1920 (Address) 2802 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem	DATE OF BURIAL. July 5, 1920
20-UNDERTAKER Joseph A. Farrell	ADDRESS 2319 Dinsmore

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 326 S. Mount St. ST.; 19 WARD)

2-FULL NAME

(Residence in Baltimore: No. 326 S. Mount St. St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Married

6-DATE OF BIRTH,

December 2, 1919
(Month) (Day) (Year)

7-AGE,

7 yrs. 1 mos. 1 da.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.....

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).....

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

JUL 5 - 1920

Blair P. Harrison
Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 3, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 3, 1920, to July 3, 1920,that I saw him alive on July 3, 1920,and that death occurred, on the date stated above, at 7 1/2 m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

.....

.....

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Joseph C. Valentini M. D.July 5, 1920 (Address) 16 S. Mount St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Vincent Cemetery

DATE OF BURIAL,

July 5, 1920

20-UNDERTAKER

Harry H. W. Igle

ADDRESS

1531 W. Lombard

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Hebrew Hospital*
CITY OF BALTIMORE: (No. *Monument St.* ST.; *2* WARD)
2-FULL NAME *Louis Greenberg*
(Residence in Baltimore: No. *2001 E. Pratt St.* St.; *18* yrs., *1* mo., *18* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*
4-COLOR OR RACE. *White*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
6-DATE OF BIRTH. *Unknown*, *1873*
(Month) (Day) (Year)
7-AGE. *47* yrs., *—* mo., *—* ds.
If LESS than 1 day, ... hrs. or ... min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Cutter*
(b) General nature of industry, business, or establishment in which employed (or employer). *Pressers*

9-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

5-1920

Robert P. Harrison,

191

Registrar.

Burial Permit *clerk*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 4, 1920*
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *June 27, 1920*, to *July 4, 1920*, that I saw him alive on *July 4, 1920*, and that death occurred, on the date stated above, at *8²⁰ A.M.*

The CAUSE OF DEATH* was as follows:

pericarditis - pneumonia - (post-operative)
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Signed) *Charles J. Ray* M. D.
7-4-1920, 1921. (Address) *Hebrew Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. *7* ds. In the *15* State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? *at home*

Former or usual residence *2001 E Pratt St*

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew Hospital

7-5-1920

20-UNDERTAKER

ADDRESS

Jack Lewis

1411 E Pratt St

To the Health Department,

City of Baltimore.

I hereby certify that I have issued a Death Certificate on the 4th day of July 1920, for Louis Greenberg, who died at the Hebrew Hospital.

At the time the said Louis Greenberg entered the hospital his name was entered on the book as Louis Greenberg, instead of which it should had been Ozor Greenberg.

Witness

Dorothy E. Feri

Charles A. Levy, M.D.

Test:

State of Maryland, City of Baltimore, to wit:

I hereby certify that on this day *10th Day July* in the year One Thousand Nine Hundred and *20*---, before me, the subscriber, a Notary Public, of the State of Maryland, in and for the City of Baltimore, aforesaid, personally appeared the above named *Dr. Charles A. Levy* and made oath in due form law that the matter and things, above stated are true and bona-fide.

As witness my hand and notarial seal.

Dorothy E. Feri
Notary Public

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

10.44517

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.44517

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St. Ignace Hospital

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Robert

(a) RESIDENCE. NO.

138 McPhail St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 3/20

7 AGE

Years

Months

Days

Infant

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Mr. Robert

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mrs. Haeckel

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Mr. Robert P. Harrison, 138 McPhail St.

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

7-3-1920

17

I HEREBY CERTIFY, That I attended deceased from

7-3-1920, to 7-3-1920

that I last saw him alive on 7-3-1920

and that death occurred, on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:

Asphyxiation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Breech Presentation

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? ☒ Date ofWas there an autopsy? ☒ no

What test confirmed diagnosis?

(Signed) C. H. Adams, M. D.

, 19 (Address) St. Ignace Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cemetery July 6 1920

20 UNDERTAKER

ADDRESS

F. B. Wappert 2236 Fredk Ave

JUL 5 - 1920

D.44518 HEALTH DEPARTMENT—CITY OF BALTIMORE D.44518

CERTIFICATE OF DEATH.

1752002

1-PLACE OF DEATH *St. Joseph Hospital*
CITY OF BALTIMORE (NO. *9* ST. *9* WARD)
2-FULL NAME *Catherine A. Holt*
(Residence in Baltimore: No. *647 Gutman Ave*)

REGISTERED NO. C

(If death occurred in hospital or institution give its NAME instead of street and number fill out No. 18.)

St.; yrs., mos.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*
4-COLOR OR RACE, *White*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)
6-DATE OF BIRTH, *Feb 24, 1*
(Month) (Day) (Year)

7-AGE, *43* yrs., mos., ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *At Home*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Maryland*

10-NAME OF FATHER, *Charles E. Holt*

11-BIRTHPLACE OF FATHER (State or Country), *Maryland*

12-MAIDEN NAME OF MOTHER *Catherine Kempe*

13-BIRTHPLACE OF MOTHER (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Mrs M.D. Fay Bonte
(Informant)
647 Gutman Ave
(Address)

15-JULY 5, 1920
Filed *1920* Robert P. Harrison,
Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 5, 1920*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I am in charge of remains described above, held as *inquest*
(Inquest, autopsy or inquiry)

therein and from the evidence obtained by said *inquest*
(Inquest, autopsy or inquiry)

inquest find that said deceased came to *death*
topsy or inquiry on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic motorcycle
run into automobile
(Duration) yrs. mos.

CONTRIBUTORY (Secondary)

(Signed) *Wm. J. Miller* M. D.
(Coroner.)
55, 1912 (Address) *48 West*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Londontown*DATE OF BURIAL, *7/6*, 19*20*20-UNDERTAKER *McLean*ADDRESS *5076 North*

D. 44519 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 44519

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 of Duncan. ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1823 of Duncan St.; 1 yrs., 1 mos., 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

May 20, 1919

7-AGE,

1 yrs., 1 mos., 7 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

none

9-BIRTHPLACE,

(State or Country),

Baltimore Md.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. J. Taylor,

(Address) 1823 Duncan St.

15-

Filed 5-1920 Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 2, 1920

17- I HEREBY CERTIFY, That I attended deceased from

May 27, 1920, to July 2, 1920,

that I saw him alive on July 2, 1920,

and that death occurred, on the date stated above, at 10 p.m.

The CAUSE OF DEATH* was as follows:

Pyrexia Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ... yrs. ... mos. ... ds.

(Signed) Frederick E. Stowers, M. D.

July 4, 1920 (Address) 1301 N. Patton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cap Lane Cemetery July 5, 1920

20-UNDERTAKER ADDRESS

Geo. C. Miller 2334 Jaffer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44520

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 Madison Ave. ST.; 14 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1511 Madison Ave. St.; 20 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH,

Nov 11, 1850
(Month) (Day) (Year)

7-AGE,

69 yrs., 7 mos., 21 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

none9-BIRTHPLACE,
(State or Country),N. Y.

PARENTS.

10-NAME OF FATHER,

Edward Merkel11-BIRTHPLACE OF FATHER
(State or Country),Germany

12-MAIDEN NAME OF MOTHER

Maria Kramer13-BIRTHPLACE OF MOTHER
(State or Country),Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. E. B. Fox(Address) 1511 Madison Ave.

15-

Robert P. Harrison,Filed July 5 - 1920

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 2nd, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 1 1919, to July 2nd 1920.that I saw her alive on June 29 1920.and that death occurred, on the date stated above, at 2:45 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia(Duration) 6 yrs., 6 mos., 6 ds.CONTRIBUTORY.
(Secondary)(Duration) 1 yrs., 6 mos., 6 ds.(Signed) Samuel A. Fox M. D.7/4, 1920. (Address) Baltimore, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Westminster

DATE OF BURIAL,

July 5, 1920

20-UNDERTAKER

W. M. Rouse

ADDRESS

230 N. Green

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PLACE OF DEATH should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3025 Westwood Avenue ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Everett Leineweber(Residence in Baltimore: No. 3025 Westwood Avenue St.; 15 yrs. 28 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Male</u>	4-COLOR OR RACE, <u>White</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <u>Single</u>
6-DATE OF BIRTH, <u>Sept 15, 1891</u> (Month) (Day) (Year)		
7-AGE, <u>22</u> yrs. <u>9</u> mos. <u>18</u> ds.		If LESS than 1 day,hrs. or....min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <u>Mechanic</u> (b) General nature of industry, business, or establishment in which employed (or employer). <u>Auto</u>		
9-BIRTHPLACE, (State or Country). <u>Baltimore</u>		

PARENTS.

10-NAME OF FATHER, <u>F L Leineweber</u>
11-BIRTHPLACE OF FATHER (State or Country). <u>Germany</u>
12-MAIDEN NAME OF MOTHER <u>Margaret E White</u>
13-BIRTHPLACE OF MOTHER (State or Country). <u>Pa.</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F L Leineweber
(Address) 3025 Westwood Ave

15-

Robert P. Harrison,Filed 5-1920191Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 3rd, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from May 12th, 1920, to July 3rd, 1920,that I saw him alive on July 3rd, 1920,and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary TuberculosisAbout (Duration) 1 yrs. 7 mos. 7 ds.CONTRIBUTORY Influenza
(Secondary)(Signed) O. R. Stewart M. D.July 3rd, 1920 (Address) 1817 N. Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 9 mos. 18 ds. In the State Pa. yrs. 9 mos. 18 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Landon Park

DATE OF BURIAL,

July 5, 1920

20-UNDERTAKER

H M Routson

ADDRESS

230 N. Green

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

D. 44522

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44522

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *6 E. Hamburg*ST.: *23* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Elizabeth Kopf*(Residence in Baltimore: No. *6 E. Hamburg St.*St.: *22* yrs., *-* mos. *27* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH, *June 7, 1891*

(Month)

(Day)

(Year)

7-AGE, *29* yrs., *-* mos. *27* ds.IF LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Ind*10-NAME OF FATHER, *Charles F. Kopf*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Barbara Brown*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Barbara Kopf*(Address) *6 E. Hamburg St.*

15-

Filed *July 5 - 1920* Robert P. Harrison,

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 4, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *May 8, 1920*, to *July 4, 1920*,that I saw her alive on *July 3, 1920*,and that death occurred, on the date stated above, at *7:49* m.

The CAUSE OF DEATH* was as follows:

Primary Tuberculosis(Duration) yrs. *1* mos. *26* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. *1* mos. *26* ds.(Signed) *W. S. Smith* M. D.*July 4, 1920* (Address) *109 W. La. St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cath Hill Cem*DATE OF BURIAL, *July 6, 1920*20-UNDERTAKER, *Schloman & Son*ADDRESS, *1039 Hanover St*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN should state EXACTLY what he stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

0.44523 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Balto General Hospital* ST. *109* WARD)2-FULL NAME *Bessie Shaneybrook Bossert*(a) RESIDENCE, NO. *1936 W. Mulberry* ST.,

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

How long in U. S., if of foreign birth? *32* yrs. *4* mos. *26* ds.

WARD.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of

*Wife of Lewis A Bossert*6 DATE OF BIRTH (month, day, and year) *Feb. 6 - 1888*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*32**4**36*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Seamstress 069

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Jacob A. Shaneybrook

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa

12 MAIDEN NAME OF MOTHER

Jennie Hochell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md.

14

Informant (Address)

Mrs Jennie Shaneybrook 410 W. 23rd St

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *7-2* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from *June 30*, 19*20*, to *July 2*, 19*20*, that I last saw her alive on *July 2*, 19*20*, and that death occurred, on the date stated above, at *8:45 P* m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction(duration) yrs. mos. *5* ds.

CONTRIBUTORY (Secondary)

Peritonitis(duration) yrs. mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes*. Date of *June 30, 20*Was there an autopsy? *no*.

What test confirmed diagnosis?

(Signed)

J. P. Ponte, Jr. M. D.

, 19 (Address)

1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**July 5* 19*20*

20 UNDERTAKER

*Geo. L. Schwat & Bro**2011 East Ave*

JUL 5 - 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 Shields ST. 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1124 Shields St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE

colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

single

6-DATE OF BIRTH,

unknown, 1871
(Month) (Day) (Year)

7-AGE,

49 yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Driver

9-BIRTHPLACE,

(State or Country)

(Baltimore) Md.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Cassie Hall
1124 Shields St.

15-

Robert P. Harrison,

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July, 2, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Oct. 16 1919, to July 2 1920, that I saw him alive on July 2 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cancer Rectum
(Duration) 12 yrs. 12 mos. ds.

CONTRIBUTORY (Secondary)

Exhaustion
(Duration) 12 yrs. 12 mos. ds.

(Signed)

W. B. E. Wagner M. D.July 5, 1920 (Address) 11769 Linden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

St. Peters. Care July 5, 1920
Paul J. Kennedy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *John Hopkins Hosp* ST.; *5* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Morris Bailey*(a) RESIDENCE. NO. *1411 May St.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Child*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Child*6 DATE OF BIRTH (month, day, and year) *Oct 30 1919*7 AGE Years *7* Months *3* Days *3* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)10 NAME OF FATHER *Deerson Bailey*11 BIRTHPLACE OF FATHER (city or town) *Maryland* (State or country)12 MAIDEN NAME OF MOTHER *Sarah Johnson*13 BIRTHPLACE OF MOTHER (city or town) *Maryland* (State or country)14 Informant *Hospital Record* (Address) *J. H. H.*15 Filed *Robert B. Harrison* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 3 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*Jan 29 1920 to July 3 1920*that I last saw him live on *July 3 1920*and that death occurred, on the date stated above, at *12:00* m.

The CAUSE OF DEATH* was as follows:

Dysentery acute(duration) yrs. mos. ds. *8*CONTRIBUTORY *Hereditary syphilis* (Secondary)(duration) yrs. mos. ds. *Beret*18 Where was disease contracted *pts home* If not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Stool culture + Wassermann +*(Signed) *W. H. H.* M. D., 19 (Address) *1411 May St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Grand View* DATE OF BURIAL *July 5 1920*20 UNDERTAKER *Samuel Hensley*ADDRESS *1411 May St.*

N. B.—WRITE PLAINLY, WITH UNFADING INK.—Information should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 5-1920

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1228 Bayard* ST. *21* WARD)2-FULL NAME *John R. Carroll*(a) RESIDENCE. No. *1228 Bayard* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1* yrs. *4* mos. *29* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *—*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *—*6 DATE OF BIRTH (month, day, and year) *July 5, 1919*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *1* *4* *29*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *—*(b) General nature of industry, business, or establishment in which employed (or employer) *—*(c) Name of employer *—*9 BIRTHPLACE (city or town) *Baltimore* (State or country)10 NAME OF FATHER *Charles Carroll*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country)12 MAIDEN NAME OF MOTHER *Anna Hers*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country)14 Informant *Charles Carroll* (Address) *1228 Bayard St*15 Filed *5-19-20* 19 *20* Registrar *Robert P. Harrison*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 3* 19 *20*17 HEREBY CERTIFY That I attended deceased from *June 27, 1920* to *July 3, 1920* that I last saw him alive on *July 3, 1920* and that death occurred, on the date stated above, at *6* m.

The CAUSE OF DEATH* was as follows:

*Gastric Entero*CONTRIBUTORY *—* (duration) yrs. mos. ds. 7

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Joseph A. Drane*, M. D.19 (Address) *1227 Columbia Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery *July 5, 1920*

20 UNDERTAKER ADDRESS

John F. Cawson & Son *901 State*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PRELIMINARY STATEMENT. PH. STATEMENTS should state EXACTLY what should be stated EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 S. Third ST. 26 WARD)

2-FULL NAME Antonino C. Bonvegna

(a) RESIDENCE. No. 423 S. Third ST. 26 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/1/20

7 AGE Years 3 Months 3 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Salvatore Bonvegna

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Lucia Discaro

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Salvatore Bonvegna
423 S. Third St.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/3/20, 19

17 I HEREBY CERTIFY, That I attended deceased from

June 1st, 1920, to July 3rd, 1920.

that I last saw him alive on July 3rd, 1920.

and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY acute Bronchitis with acute colitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys Exam

(Signed) Samuel H. Smith, M. D.

, 19 (Address) 1206 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Sacred Heart Cemetery 7/5/20

20 UNDERTAKER ADDRESS

George J. Puth 1735 - Harbor

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 44528

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44528

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 402 Ogden St. 17 WARD)

2-FULL NAME

Robert Wilson

(Residence in Baltimore: No. 402 Ogden St.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

May 24, 1920

7-AGE,

6 weeks

It LESS than 1 day.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE.
(State or Country),

Balt Md

10-NAME OF FATHER,

Robert Wilson

11-BIRTHPLACE OF FATHER
(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Ella Robinson

13-BIRTHPLACE OF MOTHER
(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Remond St.

15-

Filed July 5 - 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 4, 1920

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

And that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Gastroenteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Do not know

(Duration) yrs. mos. ds.

(Signed) W. H. Harrison, M. D.

7-5, 1917 (Address) 117 W. Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Our Auburn Ave

July 5, 1920

20-UNDERTAKER

Daniel Easton

Address 916 Remond St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1339 N. Fremont Ave. St.; 17 WARD)2-FULL NAME Lola Gross(Residence in Baltimore: No. 1339 N. Fremont Ave. St.; 5 yrs., mos., ds.)REGISTERED No. C D. 44529

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M.4-COLOR OR RACE C.5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single6-DATE OF BIRTH, June, 1999

(Month)

(Day)

(Year)

7-AGE, 21 yrs., 1 mos., ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....Home maid
(b) General nature of industry, business, or establishment in which employed (or employer).....private residence9-BIRTHPLACE, (State or Country), Maryland10-NAME OF FATHER, John F. Gross11-BIRTHPLACE OF FATHER (State or Country), Maryland12-MAIDEN NAME OF MOTHER Laura Louise Gross13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Denial Foster(Address) 116 Remond Ave

15-

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 3rd, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from June 30 1920, to July 3 1920,that I saw her alive on July 2 1920,and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

.....

.....

.....

..... (Duration)..... yrs. 5 mos. ds.

CONTRIBUTORY..... none to my knowledge

..... (Duration)..... yrs. mos. ds.

(Signed) Geo B Davis M. D.July 4, 1920 (Address) 211 Church St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

.....

19-PLACE OF BURIAL OR REMOVAL, Maclean AveDATE OF BURIAL, July 6, 192020-UNDERTAKER Denial FosterADDRESS 116 Remond Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of PLACE OF DEATH is very important. See instructions on back of certificate.

JUL 5 - 1920

0.44530

HEALTH DEPARTMENT—CITY OF BALTIMORE

0.44530

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Hawyard

ST.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Louis W. Angell

(a) RESIDENCE. NO.

12 Hawyard

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

22 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Life yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Euna J. Angell

6 DATE OF BIRTH (month, day, and year)

July 12 1852

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

67

67

11

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Charlottesville Va

10 NAME OF FATHER

Nelson Angell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Don't know

12 MAIDEN NAME OF MOTHER

Martha H. Angell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Don't know

14

Informant

Euna J. Angell

(Address)

12 E. Hawyard Ave

15

Filed

Robert G. Harrison,

Registrar

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

7-4

19 20

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on July 3rd 1920

and that death occurred, on the date stated above, at 4 AM m.

The CAUSE OF DEATH* was as follows:

Chronic Typhoid
Arterio Sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

J. W. N. Payson M. D.

1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Dunbar Ridge Cemetery

20 UNDERTAKER

W. B. Manning & Son

DATE OF BURIAL

7-5-1920

ADDRESS

North Schomberg

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4819 Park Heights Ave ST. 27 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Maryman Sleams(Residence in Baltimore: No. 4819 Park Heights Ave St. 8 yrs., 8 mos., 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-STATUS

Widow
(Write the word.)

6-DATE OF BIRTH.

April 23rd, 1897
(Month) (Day) (Year)

7-AGE,

8.3 yrs., 2 mos., 11 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....None9-BIRTHPLACE,
(State or Country),Balto. Co., Md.

10-NAME OF FATHER,

Benjamin P. Maryman11-BIRTHPLACE OF FATHER
(State or Country),Balto. Co., Md.

12-MAIDEN NAME OF MOTHER

Ellen Price13-BIRTHPLACE OF MOTHER
(State or Country),Balto. Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Lucy Sleams(Address) 4819 Park Heights Ave

15-

Filed.....Robert P. Harrison,
191.....

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 4th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

150 30 years 1911, to July 4th, 1920.that I saw her alive on July 3rd, 1920,and that death occurred, on the date stated above, at 5:00 a.m.

The CAUSE OF DEATH* was as follows:

Thrombosis of
arterial system
arterial system

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)Senile Dementia

(Duration).....yrs.....mos.....ds.

(Signed) Edmund C. Price, M. D.July 4th, 1920 (Address) 1000 7th

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

London ParkJuly 6th, 1920

20-UNDERTAKER

George J. Smith

ADDRESS

1000 7th

N. B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 55 yrs., 8 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the words)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on July 28, 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1205 Linden Ave

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, 7/5, 1920

20-UNDERTAKER

ADDRESS

Henry W. Mears & Son 805 N. Calvert

St.

N.B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUL 5 - 1920

Robert P. Harrison,

Burial Permit Clerk

D.44534 HEALTH DEPARTMENT—CITY OF BALTIMORE

D.44534

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2124 Fleet ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Stankowski(a) RESIDENCE, No. 2124 Fleet ST.: _____ WARD: _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds.How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Josephine Stankowski6 DATE OF BIRTH (month, day, and year) Feb 1 1859

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

6153

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

Thomson Chemical

(c) Name of employer

Brannish

9 BIRTHPLACE (city or town) (State or country)

Poland10 NAME OF FATHER Luis Stankowski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland12 MAIDEN NAME OF MOTHER Theodora Stankowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Josephine Stankowski

15

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 - 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 27, 1920, to July 3, 1920,that I last saw him alive on July 3 - 1920,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage -(duration) _____ yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death? ✓Did an operation precede death? no Date of _____Was there an autopsy? noWhat test confirmed diagnosis? no(Signed) no, M. D.19 (Address) 125 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Italy Rosary Cemetery July 6 1920

20 UNDERTAKER

ADDRESS

John M. Weber 1803 Bank St

N. B.—WRITE PLAINLY, with information should be carefully supplied. AGE should be stated. Exact statement of OCCUR- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

JUL 5 - 1920

1044535

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044535

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 36 Kelly Ave ST.; 28 WARD)

2-FULL NAME

Beda Elliott

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 36 Kelly Ave ST., 28 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Ida Elliott6 DATE OF BIRTH (month, day, and year) Unknown 18807 AGE Years 40 Months 0 Days 0 If LESS than 1 day, 0 hrs. 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Teamster 023

(b) General nature of industry, business, or establishment in which employed (or employer)

Summer Wagon

(c) Name of employer

9 BIRTHPLACE (city or town) Caroline Co (State or country) md10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown14 Informant Ida Elliott (Address) 36 Kelly Ave.15 Filed JUL 6 - 1920 ROBERT K. KAUFMAN Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 192017 I HEREBY CERTIFY, That I attended deceased from James, 19 20, July 3, 19 20.that I last saw him alive on July 3, 19 20, and that death occurred, on the date stated above, at 4:30 P.M.The CAUSE OF DEATH was as follows: Pneumonia & ESR T.B.CONTRIBUTORY (Secondary) Pneumonia (duration) 1 yrs. 3 mos. 3 ds.18 Where was disease contracted 36 Kelly Ave. If not at place of death?Did an operation precede death? N.R. Date of —Was there an autopsy? N.R.What test confirmed diagnosis? Characteristic Symptom(Signed) C. H. Finner, M. D.Address) 712 S. Broadway, R.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL July 6 192020 UNDERTAKER John H. Toadine ADDRESS 142

N. B.—WRITE CAREFULLY. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421. W Conway St. 22

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 421. W Conway St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 26-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

9.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Maryland

PARENTS

10 NAME OF FATHER

Thos. Bunday

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

14

Informant (Address)

Thos Bunday 421 W Conway St

15

Filed

JUL 6-1920

ROBERT E. EASTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 5-1920

17

I HEREBY CERTIFY, That I attended deceased from

July 2, 1920, to July 5, 1920.

that I last saw him alive on July 4, 1920

and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH was as follows:

Congenital debility
Congenital atelectasis
underweight.

(duration) yrs. mos. 9. ds.

CONTRIBUTORY (Secondary)

malnutrition

(duration) yrs. mos. 9. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis

Clinical

(Signed) M. C. Smiling M. D.

7.5.1920 Address) 687 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn

July 6 1920

20 UNDERTAKER

John H. Toodin 142 U. St. St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1046* *N. Arlington Ave.* ST. *16* WARD)2-FULL NAME *Annice Downie*(a) RESIDENCE. No. *1046* *N. Arlington Ave.* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Samuel A Downie*6 DATE OF BIRTH (month, day, and year) *Aug. 5th 1857*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*67**10**27*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Maryland*10 NAME OF FATHER *Patrick Kelly*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Ireland*12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Not known*

14

Informant
(Address)*Mrs Roberts, Daughter
1046 N. Arlington Ave.*

15

*JUL 6 - 1920**ROBERT E. KEEFER*

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 2nd 1920*

17

I HEREBY CERTIFY, That I attended deceased from

June 30, 1920, to *July 2*, 1920,that I last saw her alive on *July 2*, 1920,and that death occurred, on the date stated above, at *4:05 P.* m.

The CAUSE OF DEATH* was as follows:

*Acute yellow atrophy of
the liver*(duration) yrs. mos. *6* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Robert E. Keefe*, M. D.7-5, 1920 (Address) *120 1/2 Airgirth St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Goudon Park**July 6th 1920*

20 UNDERTAKER

ADDRESS

*A. J. Hyde & Son, 600 N. Broadway
Ches.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* 3 WARD)2-FULL NAME *George Henslin*(a) RESIDENCE, NO. *1533 Lancaster St.* WARD. *2*
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Child*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Child*6 DATE OF BIRTH (month, day, and year) *July 19 1918*7 AGE *1* Years *11* Months *16* Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto.* (State or country) *Md.*10 NAME OF FATHER *James Henslin*11 BIRTHPLACE OF FATHER (city or town) *Md.* (State or country)12 MAIDEN NAME OF MOTHER *Mary Kyzkerski*13 BIRTHPLACE OF MOTHER (city or town) *Md.* (State or country)14 Informant *Hospital Record* (Address) *St. St.*15 JUL 6 - 1920 *ROBERT H. KRAUTER* Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 4 1920*17 I HEREBY CERTIFY, That I attended deceased from *June 20*, 19*20*, to *July 4*, 19*20*, that I last saw him alive on *July 4*, 19*20*, and that death occurred, on the date stated above, at *10:00* p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia(duration) yrs. mos. *24* ds.CONTRIBUTORY *Pneumonia* (Secondary)(duration) yrs. mos. *6* ds.18 Where was disease contracted if not at place of death? *home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Frequent stool. Physical exam*(Signed) *Harold L. Higgins*, M. D.7/5, 1920 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Stanislaus Cemetery *July 7 1920*

20 UNDERTAKER ADDRESS

Lilly & Zeiler *403 S. Wolfe St.*

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

10 44539 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 S. Wolfe ST. V WARD)

2-FULL NAME

(a) RESIDENCE. NO. 730 S. Wolfe ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

1 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

JUL 6 - 1920

ROBERT A. FLAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

June 23rd, 1920, to July 2nd, 1920,that I last saw him alive on July 2nd, 1920,

and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Menden J. Giering, M. D.

1955 1920 (Address) 1900 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer 7/6/1920

20 UNDERTAKER

J. G. Moran E. Balt

N. B.—WRITE PLAINLY, WITH CARE. AGE should be stated EXACTLY. PHYSICIAN'S statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044540

CERTIFICATE OF DEATH.

114 1044540
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE, MD.

ST. 16

WARD

2-FULL NAME

Theodosia Johnson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1213 N. Stricker

St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, April 12, 1847 (Month) (Day) (Year)

7-AGE, 73 yrs., 2 mos., 20 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto Co

10-NAME OF FATHER, James Ritch

11-BIRTHPLACE OF FATHER (State or Country), Balto Co

12-MAIDEN NAME OF MOTHER, Dont know

13-BIRTHPLACE OF MOTHER (State or Country), Dont know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Johnson

(Address) 1213 N. Stricker St.

15-

Filed JUL 6-1920

ROBERT A. LEAUTEA

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 3, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 31, 1920, to July 3, 1920, that I saw her alive on July 3, 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Catarrhal Cholangitis & Cholelithiasis (Duration) Unknown

CONTRIBUTORY (Secondary) Intermittent

(Signed) Chas. C. Conser M. D. 7/4/20 (Address) 1101 N. Fullin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Landon Park

DATE OF BURIAL,

July 6, 1920

20-UNDERTAKER

Joseph Ahrens

ADDRESS

221 N. B. Way

N.B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION, CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE SHOULD BE STATED IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. See instructions on back of certificate.

10-44541 HEALTH DEPARTMENT—CITY OF BALTIMORE 10-44541
170

1 PLACE OF DEATH
CITY OF BALTIMORE: (No. 205 N. Carrollton St. 16 WARD)
2-FULL NAME Mary E. Thiede
(Residence in Baltimore: No. 205 N. Carrollton St. 79 yrs. 6 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female	4-COLOR OR RACE White	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed
6-DATE OF BIRTH Dec. 24, 1840 (Month) (Day) (Year)		
7-AGE 79 yrs. 6 mos. 9 ds. or min.? If LESS than 1 day, hrs.		
8-OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None		
9-BIRTHPLACE (State or country) Baltimore, Md.		
PARENTS	10-NAME OF FATHER Mr. Pirtsch	
	11-BIRTHPLACE OF FATHER (State or country) Germany	
	12-MAIDEN NAME OF MOTHER Not Given	
	13-BIRTHPLACE OF MOTHER (State or country) Not Given	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Anna L. Bruce
(for Dr. G. G. G. G.)
(Address) 705 N. Carrollton St.

15-
Filed JUL 6 1920 ROBERT E. KRAUTER
BURIAL PLACE REGISTERED

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH
July 3, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 13, 1920, to July 3, 1920, that I saw him alive on July 3, 1920, and that death occurred, on the date stated above, at 4:10 p. m. The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis
unknown (Duration) yrs. mos. ds.
Contributory (SECONDARY)
(Signed) Charles G. G. G. M. D.
1920 [Address] 1111 N. Lombard St.
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]
At place of death yrs. mos. ds. in the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence
19-PLACE OF BURIAL OR REMOVAL
Grave Ridge Co. DATE OF BURIAL
July 6, 1920
20-UNDERTAKER
Joseph B. Cook ADDRESS
1003 N. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Int. St. Agnes Calvary* WARD)2-FULL NAME *Lester M. Barrowes Slattery*(a) RESIDENCE. NO. *Int. St. Agnes Calvary* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *45* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Oct 20 - 1836*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*85*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sister of Mary

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*St. Island*

10 NAME OF FATHER

*James*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Ireland*

12 MAIDEN NAME OF MOTHER

*Alice*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Ireland*

14

Informant
(Address)*Sister Superior
St. Agnes Convent*

15

Filed

JUL 6 - 1920

ROBERT B. FLAUTE
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 5* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

Mar 1, 19*20*, to *July 5*, 19*20*,that I last saw *her* alive on *July 4*, 19*20*,and that death occurred, on the date stated above, at *2.30 a. m.*

The CAUSE OF DEATH* was as follows:

*Cerebral Embolus*CONTRIBUTORY (Secondary) *Arterio Sclerosis*
(duration) *10* yrs. *2* mos. *2* ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Emil S. Meyer*, M. D.

7/6, 1920 (Address)

2438 Euterio Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Agnes Convent**July 7* 19*20*

20 UNDERTAKER

ADDRESS

H. J. Jenkins & Son Co. Old

Information should be carefully supplied. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 Mt Royal St. WARD 41)2-FULL NAME Kate B. White(a) RESIDENCE. No. 1223 Mt Royal St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds.How long in U. S., if of foreign birth? 14 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 ~~Single~~ Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced Widowed
If Widowed of Wife of Mr. L. White6 DATE OF BIRTH (month, day, and year) Aug 15 1840

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ohio
(State or country)10 NAME OF FATHER E. C. Locos11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)12 MAIDEN NAME OF MOTHER K. Melin13 BIRTHPLACE OF MOTHER (city or town) N.Y.
(State or country)

14

Informant Rob L. White
(Address) 1223 Mt Royal St.

15

JUL 6 - 1920

ROBERT B. KRAMER
RegistrarBurial Permit No. 1044544

* Objective & subjective signs & symptoms

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5th, 192017 I HEREBY CERTIFY, That I attended deceased from April 24th, 1915 to July 5th, 1920,
that I last saw her alive on July 5th, 1920,
and that death occurred, on the date stated above, at 8:50 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial
Alveolar Nephritis, of
at least 15 years
duration (duration) 15 yrs. mos. ds.CONTRIBUTORY
(Secondary)problematic (duration) 15 yrs. mos. ds.18 Where was disease contracted
if not at place of death? XDid an operation precede death? No. Date of XWas there an autopsy? No.What test confirmed diagnosis? Objective & subjective(Signed) Edward C. Moore M. D., 19 (Address) 1012 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Ignace CemeteryDATE OF BURIAL July 7 192020 UNDERTAKER St. Ignace Cemetery

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 S. Duncan ST.: 1 WARD)2-FULL NAME Annie Bennett(a) RESIDENCE. NO. 217 S. Duncan ST. 1 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

60 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F4 COLOR OR RACE Col5 Single, Married, Widowed, or Divorced (write the word) married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Bennett6 DATE OF BIRTH (month, day, and year) July 18 1856

7 AGE

Years 64

Months

Days

If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress(b) General nature of industry, business, or establishment in which employed (or employer) Laundry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER James Denby11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Paul Sutherland13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14

Informant (Address) Abraham Bennett

15

Filed

19

ROBERT B. EBARTER Registrar

JUL 6 - 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 1 1920, to July 2 1920that I last saw him alive on July 2 1920and that death occurred, on the date stated above, at 8:20 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy - (Cerebral hemorrhage) - Natural
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ____Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. C. Burgess, M. D.19 (Address) 2218 E. Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

John W. HendersonADDRESS 1502E. Mount

N. B.—WRITE PLAINLY, with ink. Exact statement of OCCURRENCE should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 Maryland Ave ST.: West WARD)

2-FULL NAME

Elizabeth E. Snyder

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE, NO.

127 Maryland Ave ST.: West WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth 1 yrs. 1 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofEdmund Snyder

6 DATE OF BIRTH (month, day, and year)

— 1856

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.64

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workNone(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Glenburnie
A.A.C. Md

10 NAME OF FATHER

Thomas Gaither11 BIRTHPLACE OF FATHER (city or town)
(State or country)Maryland

12 MAIDEN NAME OF MOTHER

Not Known13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Maryland

14

Informant
(Address)Mary M. L. Wall
127 Maryland Ave

15

Filed

JUL 6 1920ROBERT B. LAUTER

Registrar

BURIAL PERMIT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 3rd 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 1920, 1920.

that I last saw her alive on

July 2, 1920.and that death occurred, on the date stated above, at 11:25 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary
phthisis
(duration) 3 yrs. 10 mos. 20 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald S. Elam, M. D., 19 (Address) Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Redeeming Ground A.A.C. Md July 6 1920

20 UNDERTAKER

ADDRESS

JOHN F. DENNY715 LIGHT S

Information should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

1044547

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044547

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1532 M Elderry St.

WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary Ross

(Residence in Baltimore: No.

1532 M Elderry St.

1 yrs. 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

widow

6-DATE OF BIRTH

June 19, 1891
(Month) (Day) (Year)

7-AGE,

29 yrs. 14 mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Domestic

9-BIRTHPLACE,

(State or Country),

N. C.

10-NAME OF FATHER,

Wm. Crockett

11-BIRTHPLACE OF FATHER

(State or Country),

N. C.

12-MAIDEN NAME OF MOTHER

Alice Crockett

13-BIRTHPLACE OF MOTHER

(State or Country),

Ga.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Alice M. Laine

(Address)

1532 M Elderry St.

15-

JUL 6 - 1920

ROBERT B. LEAUTE

Filed

191

Baltimore City Health Department Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 3, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 5, 1920, to July 3, 1920,

that I saw her alive on July 2, 1920,

and that death occurred, on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH* was as follows:

Phtusis Pulmonalis

(Duration).....yrs. 8 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs. ds.

(Signed) H. S. McCard M. D.

76... 1920 (Address) 2000 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. mos. ds. In the State.....yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Asbury Cem.

DATE OF BURIAL

July 6, 1920

20-UNDERTAKER

Chris. H. Johnson

ADDRESS

Caroline

1044548

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044548

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 334 S Monroe ST. 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 334 S Monroe St.; yrs. mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

M

4-COLOR OR RACE,

W.

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.) Single

6-DATE OF BIRTH,

June 12, 1920
(Month) (Day) (Year)

7-AGE,

23 yrs. mos. ds.

If LESS than 1 day
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

City

10-NAME OF FATHER,

John J. Kane

11-BIRTHPLACE OF FATHER (State or Country),

W. Va

12-MAIDEN NAME OF MOTHER

Genevieve Turner

13-BIRTHPLACE OF MOTHER (State or Country),

City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Kane

(Address) 334 S. Monroe

15-

JUL 6 - 1920

ROBERT K. LAUTER

Filed

191

BALTIMORE CITY REGISTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 5, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 3, 1920, to July 5, 1920,

that I saw him alive on July 5, 1920,

and that death occurred, on the date stated above, at 3:40 p.m.

The CAUSE OF DEATH* was as follows:

Congestive Atelectasis

(Duration) yrs. mos. ds. 23

CONTRIBUTORY (Secondary)

Coronary Arteriosclerosis

(Duration) yrs. mos. ds. 3

(Signed) Edward W. Coulahan, M. D.

July 6, 1920. (Address) 124 N. Fullerton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park

DATE OF BURIAL,

July 6, 1920.

20-UNDERTAKER

Geo. E. Schmit & Bros 2101 E. Pratt Ave

N. B.—Every item of information in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph Hospital* ST. *10* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *910. E. Chase* ST. *10* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. *0* mos. *0* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

*Married*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Belle Schaffer*

6 DATE OF BIRTH (month, day, and year)

May 8-1885

7 AGE

Years

Months

Days

If LESS than
1 day, ... hrs.
or ... min.*65 yrs. May 8*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

Washington apt.

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore*

10 NAME OF FATHER

*John Schaffer*11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

*May Stahl*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Baltimore*

14

Informant
(Address)*Belle Schaffer
910 E. Chase St.
Baltimore*

JUL 6-1920

Burial Permit *Robert A. Trautman*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 5 1920

17

HEREBY CERTIFY, That I attended deceased from

June 7 1920 to *July 5 1920*that I last saw him alive on *July 5 1920*and that death occurred, on the date stated above, at *12 P.M.*

The CAUSE OF DEATH* was as follows:

*Uremia
Support Prostate Gland.
Operation preceding death.*(duration) *7* yrs. *0* mos. *0* ds.CONTRIBUTORY
(Secondary)(duration) *7* yrs. *0* mos. *0* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *Yes* Date of *July 5 1920*Was there an autopsy? *No*

What test confirmed diagnosis?

Clinical findings

(Signed)

F. C. Marino, M.D.

19 (Address)

St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Baltimore Cemetery**July 7 1920*

20 UNDERTAKER

ADDRESS

*William Cook**N 43 W*

Information should be carefully supplied. Cause of DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

1044550 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 245-Monticello Terrace ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Guinevere V. Rice(a) RESIDENCE. NO. 245-Monticello Terrace

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X6 DATE OF BIRTH (month, day, and year) March 15 18807 AGE Years 40 Months 3 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Milliner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)10 NAME OF FATHER Robert A. Rice11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)12 MAIDEN NAME OF MOTHER Maryland Elliot13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)14 Informant Edwina Rice
(Address) 245-Monticello Terrace15 Filed JUL 6 - 1920 to ROBERT A. LEAUTEA
Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 192017 I HEREBY CERTIFY, That I attended deceased from July 4, 1920, to July 4, 1920, that I last saw him alive on July 4, 1920, and that death occurred, on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart and pulmonary edema.

(duration) yrs. mos. ds.

CONTRIBUTORY Myocarditis + Pulmonary edema
(Secondary) (duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? none(Signed) Sam L. Lewis, M. D., 1920 (Address) 4706 Highland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL July 7 192020 UNDERTAKER Wm Cork ADDRESS St. G. M.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044551

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1430 Holbrook

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Gerard A. Summott.

(Residence in Baltimore: No.

Life time,

St.;

yrs. 6, mos. 18, ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Jan 15th,

1920.

(Month)

(Day)

(Year)

7-AGE,

yrs. 6, mos. 18, ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

Baltimore Md.

10-NAME OF FATHER,

Charles E. Summott.

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore Md.

12-MAIDEN NAME OF MOTHER

Mary T. Toulon.

13-BIRTHPLACE OF MOTHER
(State or Country),

Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles E. Summott.

(Address) 1430 Holbrook St.

15-

JUL 6-1920

ROBERT E. KRAUTER

Filed

191

BALTIMORE CITY

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 4th

1920.

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15th 1920, to July 4th 1920, that I saw him alive on July 3rd 1920, and that death occurred, on the date stated above, at 2:15 p.m. The CAUSE OF DEATH* was as follows:

Pleuro pneumonia (Right side)

with Empyema of same side.

(Duration) yrs. mos. 19, ds.

CONTRIBUTORY
(Secondary)

Septic infection

(Duration) yrs. mos. 6, ds.

(Signed) Arthur Brinton M. D.

July 4th, 1920 (Address) 6 W. Cor. Calver

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Charles Pikesville

July 6, 1920

20-UNDERTAKER

ADDRESS

H.C. Wiedefeld 914 Greenmount Ave

N.B.—Every item of information on this certificate is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044552

1044552

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILED

191

ROBERT B. KRAUTER

BALTIMORE HEALTH DEPARTMENT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

JUN 5 1920 191, to JUL 5 1920 191,

that I saw her alive on JUL 5 1920 191,

and that death occurred, on the date stated above, at 8:00 A. M.

The CAUSE OF DEATH* was as follows:

Chorea

(Duration) 2 yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

Intestinal (Duration) 2 yrs. 3 mos. 3 ds.

(Signed) J. H. Disher M. D.

JUL 6 1920 (Address) 928 E. North Ave.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

H. C. Wiedefeld 914 Greenmount Ave

N.B.—Every item of information furnished in plain terms, so that it may be properly classified. Every item of information is important. See instructions on back of certificate.

1044553. HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 W. Biddle

ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Murray

(a) RESIDENCE. No. 532 W. Biddle

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds.

ST. WARD. (If nonresident give city or town and State) yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1920

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1920, to July 3, 1920, that I last saw him alive on July 3, 1920, and that death occurred, on the date stated above, at 11:15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) Edward J. Whelan, M. D.

1/3, 1920 (Address) 1230 David Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed or divorced HUSBAND of

WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE 47 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

JUL 6 - 1920

ROBERT B. KAUTER

Registrar

Burial Permit Clerk

Information should be carefully supplied so that it may be properly checked. CAUSE OF DEATH in plain terms, so that it may be properly checked. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2241* *Murphy St.* ST.: *8* WARD)

2-FULL NAME

Madeline B. Raymond

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

(Usual place of abode)

2241 *Murphy St.* ST.: *8* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2* mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 2, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*2**2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Joseph Raymond

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Catherine Reid

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Mr. J. S. Raymond
2241 *Murphy St.*

15

File

*JUL 6 - 1920**ROBERT E. KAUFMAN**Bureau of Health*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 5* 19 *20*

17

I HEREBY CERTIFY, That I attended deceased from *July 5*, 192*0*, to *July 5* *7*³⁰, 192*0*, that I last saw her alive on *July 5*, 192*0*, and that death occurred, on the date stated above, at *7*³⁰ P. M.

The CAUSE OF DEATH* was as follows:

Mal Nutrition had been
looming right since birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 2 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Thomas J. Ommen* M. D., 19 (Address) *1075 N. York St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Baltimore City**July 6* 19 *20*

20 UNDERTAKER

ADDRESS

*Spring House, Md**131 E. 1st St.*

Match number of Certificate of Death in plain terms, so that it may be properly classified. See instructions on back of certificates.

10 44555- HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Smith(a) RESIDENCE. No. 1306 Jefferson St.
(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored5 Single, Married, Widowed,
or Divorced (write the word)Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 1882

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.38

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workPainter(b) General nature of industry,
business, or establishment in
which employed (or employer)Unknown

(c) Name of employer

Unknown9 BIRTHPLACE (city or town)
(State or country)Texas

10 NAME OF FATHER

Abel Smith11 BIRTHPLACE OF FATHER (city or town)
(State or country)Maryland

12 MAIDEN NAME OF MOTHER

Teresa Mann13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Maryland

14

Informant
(Address)Hospital RecordsH.T.H.

15

JUL 6 - 1920ROBERT B. KLAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29, 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 1, 1920, to June 29, 1920,that I last saw him alive on June 29, 1920,and that death occurred, on the date stated above, at 9.30 A. M.

The CAUSE OF DEATH* was as follows:

Hodgkins disease.(duration) yrs. 2 mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

George R. Williams
6-29-20 (Address) Municipal Tbc. Hospital.*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF ~~INTERMENT~~, CREMATION ~~INTERMENT~~Bay View Hospital

DATE OF BURIAL

7/3/ 1920

ADDRESS

B.V.H.

20 UNDERTAKER

J.B. Hunter

Information should be carefully checked to insure that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

1044556

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2641 Francis A ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Eugene W. Garner

(a) RESIDENCE. NO.

2641 Francis A ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 7/1893

7 AGE

Years

Months

Days

27

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Mortician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

C R R

9 BIRTHPLACE (city or town) (State or country)

Md

10 NAME OF FATHER

Geo Garner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Georganna S.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Mrs Lennie P. Kershaw 2641 Francis A ST.

15

Filed

JUL 6 - 1920

BOBBY A. ELLIOTT

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 5 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 48, 1920, to July 4, 1920.

that I last saw him alive on July 4, 1920.

and that death occurred, on the date stated above, at 6:20 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Schickelwhite & Enders

(Signed) J. H. Schickelwhite, M. D.

, 19 (Address) 2731 Parkwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery

July 7 1920

20 UNDERTAKER

H. M. Routson

ADDRESS

2238 W. North Ave

Information should be given in plain terms, so that it may be properly understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *10*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *10*)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *married*

6-DATE OF BIRTH

February-22, 1895
(Month) (Day) (Year)

7-AGE,

25 yrs. 4 mos. 11 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Clerk. J. H.*

9-BIRTHPLACE, (State or Country),

New York.

10-NAME OF FATHER,

George Hilbre

11-BIRTHPLACE OF FATHER (State or Country),

England

12-MAIDEN NAME OF MOTHER

Elizabeth Jayko

13-BIRTHPLACE OF MOTHER (State or Country),

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Patrick J. Brady*(Address) *1111 Pen*

15-

JUL 6 - 1920

ROBERT B. KRAUTER

Filed

191

BALTIMORE REGISTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July-3, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *April-25 1920*, to *July-3 1920*, that I saw him alive on *July-2 1920*, and that death occurred, on the date stated above, at *8 a. m.*

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation - Ixemia - General Anasarca - Thrombosis right femoral vein. (Duration) yrs. mos. 14 ds. Chronic Paronychia. (Secondary) (Duration) yrs. mos. 8 ds. Nephritis (alcoholic) (Signed) William F. Schwartz M. D. July-3, 1920 (Address) Md. Penitentiary.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1 yrs. 3 mos. 28 ds.* In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Baltimore Hotel Brooklyn N.Y.*

19-PLACE OF BURIAL OR REMOVAL,

Calvary Cemetery - Brooklyn N.Y. July 6, 1920

20-UNDERTAKER

Severance (J. F. Woodin) owner

ADDRESS

108 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

1044558

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1044558
170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 301 Carey St

ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sarah A Reynolds

(a) RESIDENCE. No.

301 N Carey St

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Chas Reynolds

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

about 79

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va

10 NAME OF FATHER

John Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Hiram Sanford
301 N Carey St

15

Filed

JUL 6 - 1920

ROBERT E. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1920

17

I HEREBY CERTIFY, That I attended deceased from

Dec. 15, 1919, to June 8, 1920,

that I last saw him alive on June 8, 1920,

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis.

Indefinite duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Primary analysis

(Signed)

H. H. Arthur, M. D.

, 19

(Address)

1426 N. Carroll St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Olivet Cemetery

July 8 1920

20 UNDERTAKER

J. J. Gilmartin

ADDRESS

Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2636 M^s Elderry ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elizabeth Dressel

(a) RESIDENCE. NO.

2636 M^s Elderry

ST.,

WARD.

(Usual place of abode)

(If nonresident give city and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofMartin Dressel

6 DATE OF BIRTH (month, day, and year)

March 23, 1850

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.70311

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workHousewife(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore

10 NAME OF FATHER

Valentini Resch

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Katherine Rudenauer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

Mrs. Strasser

(Address)

2636 M^s Elderry St.

15

JUL 6 - 1920ROBERT F. ERAUTER
Registrar

Bacial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 4 1920

17

I HEREBY CERTIFY, That I attended deceased from
June 20 -, 19 20, to July 4 -, 19 20,
that I last saw her alive on July 4, 19 20,
and that death occurred, on the date stated above, at 10:10 a.m.

The CAUSE OF DEATH* was as follows:

Septic Infection - following
Riggs Dis. (Exposure Chloroform)
(duration) yrs. mos. ds.
CONTRIBUTORY Arterio-sclerosis - General
(Secondary) (duration) 1 yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? usual

(Signed)

Frank C. Brown

M. D.

19

(Address)

125 E. 1st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Balto. CemeteryJuly 7 1920

20 UNDERTAKER

ADDRESS

John Herwig & Co2008 Orleans

Information should be carefully checked in plain terms, so that it may be properly transcribed. CAUSE OF DEATH is very important. See instructions on back of certificates.

D. 44560

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44560

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Park Avenue

ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Y. Briscoe

(a) RESIDENCE. NO.

1424 Park Avenue

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

76 yrs.

7 mos.

12 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

David Briscoe

6 DATE OF BIRTH (month, day, and year)

Nov. 24, 1844

7 AGE

76

Years

7

Months

12

Days

If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore,

Maryland

10 NAME OF FATHER Augustus Penniman

11 BIRTHPLACE OF FATHER (city or town)

Baltimore,

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER Mary Atkinson Yates

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore,

(State or country)

Maryland

14

Informant F. Byrne Shepherd

(Address)

1424 Park Avenue

15

Filed

JUL 6-1920

19

JUL 6-1920

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 5, 1920

17

I HEREBY CERTIFY, That I attended deceased from

Jan

1920, to

July 5, 1920,

that I last saw her alive on

July 5, 1920,

and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH* was as follows:

Endocarditis & arthritis

(duration) 20 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Pulmonary tuberculosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

12 W. North St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. B. Thomas, M. D.

19 (Address) 1017 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. John's Cemetery, Waverly 7/7, 1920

20 UNDERTAKER

ADDRESS

Henry W. Mears & Son 805 N. Calvert St.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

Robert P. Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated in years, months and days. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

10.44561 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.44561

CERTIFICATE OF DEATH

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *8*) ST.: *8* WARD) REGISTERED No. C
2-FULL NAME *Carlton Abbott Hunt*
(Residence in Baltimore: No. *1711* *in* *Durban* St.; yrs. *7* mos. *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single*
6-DATE OF BIRTH, *Oct 29*, *1* (Month) (Day) (Year)
7-AGE, *7* yrs. *7* mos. *5* ds. If LESS than 1 day, ...hrs. or ...min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Balto*
10-NAME OF FATHER, *Frank Hunt*
11-BIRTHPLACE OF FATHER (State or Country), *Balto*
12-MAIDEN NAME OF MOTHER, *Baltic Harris*
13-BIRTHPLACE OF MOTHER (State or Country), *N. Y.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Frank Hunt*
(Address) *1711 S. L. Durban*

15- Robert P. Harrison, Registrar.
Filed *8-1920* Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 5*, *1920* (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Burns from fire
(Duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) ...
(Signed) *Wm. J. Jones* M. D. (Coroner.)
7-6, 1912 (Address) *W. J. Jones*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Balto Cemetery* DATE OF BURIAL, *July 5*, 1920
20-UNDERTAKER, *Robt J. Turner* ADDRESS *1021 N. Bond St.*

N. B.—Every item of information should be carefully supplied. AGE, unless stated, is very important. See instructions on back of certificate.

D 44562

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44562

CERTIFICATE OF DEATH.

167

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.

Hopkins Hospital
Annie M. Brogan
18 Eutan Ave,

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Bolt

6-DATE OF BIRTH

July 4, 1906
(Month) (Day) (Year)

7-AGE

6 yrs., 11 mos., 11 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore.

10-NAME OF FATHER,

Patrick Brogan

11-BIRTHPLACE OF FATHER (State or Country),

Ireland.

12-MAIDEN NAME OF MOTHER

Mary Burke.

13-BIRTHPLACE OF MOTHER (State or Country),

Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mr. Patrick Brogan
18 Eutan Ave.

15-

Robert P. Harrison,

101
Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 5, 1906
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

By gas stove with fire works.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. 7-6-20 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

New Catholic Cem. July 7, 1906

20-UNDERTAKER ADDRESS

John J. Brown & Son, 401 N. Wall St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44563

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 876 Lennon St. ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 876 Lennon St. St. 18 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH

March 1887 (Month) (Day) (Year)

7-AGE,

33 yrs. 3 mos. 24 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer) Harry M. works

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

John T. Griswell

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER,

Bertha Barrs

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. William Smith

(Address) 876 Lennon St.

15-

Robert P. Harrison,

JUL 8 - 1920

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 6th 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1st 1920 to July 6th 1920, that I saw her alive on July 5th 1920, and that death occurred, on the date stated above, at 127 m.

The CAUSE OF DEATH* was as follows:

Hypertension, Myocardial Infarction (Broken Compensation) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. H. Harrison, M. D. 7/6/1920 (Address) 888 N. Lombard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Burial Place: St. Paul's Episcopal Church, 1210 N. E. St. Undertaker: John J. Gorman, 1010 N. E. St.

D. 44564 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2102 Bolton

ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza C. Simon

(a) RESIDENCE, No. 2102 Bolton

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 11 mos. 1 ds. How long in U. S., if of foreign birth? 78 yrs. 11 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Widowed

5a If married, widowed, or divorced

(or) WIFE of

M. Simon

6 DATE OF BIRTH (month, day, and year)

Aug 3rd 1841

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

78

11

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER Conrad L. Paul

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER Anna E. Roth

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant Wm H. Paul

(Address) 2102 Bolton St.

15 Filed Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4th 1920

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1920, to July 4, 1920, that I last saw her alive on July 4, 1920, and that death occurred, on the date stated above, at 1 P. m. The CAUSE OF DEATH* was as follows:

Bronchial Effusion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Bronch. Pneumonia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Symptoms

(Signed)

Howard C. Silver

M. D.

, 192 (Address) 1914 Bolton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cem.

July 7 1920

20 UNDERTAKER

ADDRESS

Mr. & Mrs. John W. Tephel 801 W. Fayette

JUL 6-1920

Information should be carefully supplied in plain terms, so that it may be properly translated into the language of the law. See instructions on back of certificates.

10.44565 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.44565

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 E Pratt

ST. 2 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 1812 E Pratt

(Usual place of abode)

ST. WARD.

(If nonresident give city and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 11 1917

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

John Dachele

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Mary

12 MAIDEN NAME OF MOTHER

Ella Lemon

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

John Dachele 1812 E Pratt

15

Filed

19

Cert. P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

7-4

1920

17

I HEREBY CERTIFY, That I attended deceased from

June 20, 1920, to July 4, 1920,

that I last saw him alive on July 4, 1920,

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis Simple

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

Cardiac failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? 20 Date of

Was there an autopsy? 20

What test confirmed diagnosis?

(Signed) M. R. Brannan, M. D.

19 (Address) 1255 B Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Leuthendal

July 7 1920

20 UNDERTAKER

Nendell Duffels Son

ADDRESS

375 Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

JUL 6 - 1920

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

844566

CERTIFICATE OF DEATH.

15th D 44566
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 S High ST.; 3rd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 316 S High St.; — yrs., — mos., 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, July 6, 1920 (Month) (Day) (Year)

7-AGE, — yrs., — mos., 2 ds. 11-LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Ind

10-NAME OF FATHER, Giuseppe Brancistofor

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Francis Viola

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W W Day

(Address) Johns Hopkins Hospital

15 JUL 7 - 1920

ROBERT E. KRAUTER

Filed..... 191

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 6, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 4, 1920, to July 6, 1920, that I saw her alive on July 6, 1920, and that death occurred, on the date stated above, at 10⁰⁰ a.m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis
(Duration) yrs. mos. 2 ds.CONTRIBUTORY. Unknown
(Secondary)(Signed) E. E. Duncan M. D.
July 6, 1920 (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt. Hope Cemetery July 7, 1920

20-UNDERTAKER, ADDRESS

Kendall Goppel & Son 37 S Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044567

CERTIFICATE OF DEATH.

50 1044567
REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

306 W. Biddle St. 11

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

John Hecker

(Residence in Baltimore: No.

306 W. Biddle

St. 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOW, OR DIVORCED, (Write the word.)

Widow

6-DATE OF BIRTH,

May 1857

(Month)

(Day)

(Year)

7-AGE,

68

yrs.

mos.

ds.

If LESS than 1 day.

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Baker

9-BIRTHPLACE, (State or Country)

Germany

10-NAME OF FATHER,

Not known

11-BIRTHPLACE OF FATHER, (State or Country),

Not known

12-MAIDEN NAME OF MOTHER,

Not known

13-BIRTHPLACE OF MOTHER, (State or Country),

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Daniel E. Carter

(Address)

916 Orama

15-

Filed

JUL 7 - 1920

ROBERT E. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

7/5, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from 1920, to 7/6/1920, that I saw him alive on 7/4/1920, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy and Diabetic Ulcers 8 days
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Hemiplegia 8 days
(Duration) yrs. mos. ds.

(Signed)

J. E. Carter

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park

July 7, 1920

20-UNDERTAKER

Daniel E. Carter

916 Orama

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

10.44568

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 ✓ 10.44568

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

455 Colvin St
Charles Alfars
435 Colvin St

St.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

ROBERT E. KAUTER

Burial Permit

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said
(Inquest, au-topsy or inquiry.) and that said deceased came to death
on the day stated above.

The CAUSE OF DEATH* was as follows:

P. Val. de Heart
Duration yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner) 1639

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Oak Lawn Cemetery

July 7, 1922

20-UNDERTAKER

ADDRESS

Liston & Fussellbaugh 2420 St Paul St.

N. B.—Every item of information should be given in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64-1044569

1044569

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 144 Pitt St. 6 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 14 N. Patterson Pl. 6 WARD.

(Usual place of abode)
Length of residence in city or town where death occurred 60 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

85

Years

Months

Days

If LESS than
1 day, ____ hrs.
or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

JUL 7 - 1920

ROBERT E. LEAUTE
Registrar
BIRTH PLACE CLERK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

July 3, 1920, to July 5, 1920,
that I last saw her alive on July 5, 1920,
and that death occurred, on the date stated above, at 6.30 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy.

CONTRIBUTORY
(Secondary)18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Maurice Feldman, M. D.
7/7/1920 (Address) 1802 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

1044570

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044570

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 1106 William St. ST. 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Catherine M. Metzler.

45

(Residence in Baltimore: No.

1106 William St.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single. (Write the word.)

6-DATE OF BIRTH, February 16th, 1871, / (Month) (Day) (Year)

7-AGE, 49 yrs., 4 mos., 19 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Music teacher. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), California.

10-NAME OF FATHER, Frank A. Metzler.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Maria M. Deitz.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Metzler. (brother)

(Address) 1106 William St.

15-

JUL 7 - 1920

Filed

101

ROBERT S. KRAUTER

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 5th, 1920, 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remanum described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide.
Illuminating gas poisoning.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

July 5th, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery DATE OF BURIAL, 7/7/20

20-UNDERTAKER

Mr. J. E. Swander 1425 Charles St.

1044571

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044571

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1353 Carroll

ST. 21

WARD)

REGISTERED NO. C

2-FULL NAME

Alveta Ray

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1353 Carroll

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Caucasian

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH,

July 1, 1912
(Month) (Day) (Year)

7-AGE,

17 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Chemist

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country),

Md

10-NAME OF FATHER,

Nelson Ray

11-BIRTHPLACE OF FATHER

(State or Country),

Md

12-MAIDEN NAME OF MOTHER

S. Salella Ray

13-BIRTHPLACE OF MOTHER

(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

S. Salella Ray

(Address)

1353 Carroll St.

15-

JUL 7 - 1920

ROBERT E. RAUTER

Filed

191

BUTLER PETERSEN

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 3, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1, 1912, to July 3, 1912,

that I saw him alive on July 3, 1912,

and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Strangulated Gut

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

July 7, 1912. (Address) 227 S. Carroll St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Zion Cemetery

July 7, 1920

20-UNDERTAKER

ADDRESS

Charles B. Jones

211 Pine

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

10. 44572

HEALTH DEPARTMENT—CITY OF BALTIMORE

84 1044572

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 746 W Franklin ST.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Thos. Reiston

(Residence in Baltimore: No. 746 W Franklin

St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

C.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Mar

6-DATE OF BIRTH,

Aug 15, 1872

7-AGE,

47 yrs. 10 mos. 20 da.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... Driving Automobile Truck
(b) General nature of industry, business, or establishment in which employed (or employer)... Express Co. Dr.

9-BIRTHPLACE, (State or Country),

Bacc Md

10-NAME OF FATHER,

Robert Reister

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Rachel Reed

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Hattie Reiston

(Address)

746 W Franklin

15-

JUL 7-1920

ROBERT E. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 5, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 24 1912, to July 5 1912.

that I saw h... alive on July 5 1912.

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Suppuration of dentia
Cervical

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

Septic Infection

(Signed)

J. H. Norwood M. D.

July 5, 1912 (Address) 939 W Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Zion Cem

DATE OF BURIAL,

July 8, 1912

20-UNDERTAKER

Cumberook 502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

1044573

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044573

1-PLACE OF DEATH

Bayview Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 10

WARD)

2-FULL NAME

Arthur Thomas

(a) RESIDENCE. No.

1213 N. Spring

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male Black

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1887

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

33.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Writer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Do.

14

Informant (Address)

Bayview Hospital, Baltimore, Md.

15

File

JUL 7 - 1920

ROBERT E. LEAUTEAU Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 5, 1920

17

I HEREBY CERTIFY, That I attended deceased from

April 3, 1920, to July 4, 1920

that I last saw him alive on July 4, 1920

and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the brain)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Furber's Euphorbia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. W. Henderson

M. D.

7/5/20 (Address)

Bayview Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

John W. Henderson July 8, 1920

20 UNDERTAKER

ADDRESS

John W. Henderson & Son

1044574

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 167

1044574

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).9-BIRTHPLACE,
(State or Country),10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country),12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILED

JUL 7-1920

ROBERT E. BRADY

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

1920.
(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Barium firework;

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Signed)

(Coroner)

7-7, 1920 (Address) 45. Leach

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran-
sients, or Recent Residents).

At place

In the

of death...yrs...mos...ds. State...yrs...mos...ds.

Where was disease contracted, if not at place of death?...

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044575

D44575

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Church Home and Infirmary.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

26 N. Broadway

ST.: 9

WARD)

2-FULL NAME

Mrs. Louise Brown

(a) RESIDENCE. NO.

2106 Hartford Ave. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

15 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

15 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John W. Brown

6 DATE OF BIRTH (month, day, and year)

May 23rd 1899

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

21

1

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Accomac Va.

10 NAME OF FATHER

John Beignell

11 BIRTHPLACE OF FATHER (city or town)

Md.

(State or country)

12 MAIDEN NAME OF MOTHER

Louise Beignell

13 BIRTHPLACE OF MOTHER (city or town)

Accomac Va.

(State or country)

14

Informant (Address)

John Beignell
2106 Hartford Ave.

15

Filed JUL 7 - 1920

ROBERT F. BRADY

BRIAL PRINT-DEAL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 5th 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 22, 1920, to July 5, 1920.

that I last saw her alive on

July 5, 1920.

and that death occurred, on the date stated above, at

6:30 P. m.

The CAUSE OF DEATH* was as follows:

In complete Abortion. Infected from fall.

(duration)

yrs.

1 mos.

7 ds.

CONTRIBUTORY (Secondary)

Septicemia

(duration)

yrs.

mos.

7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Yes

Date of June 22-1920

Was there an autopsy?

Yes.

What test confirmed diagnosis? Operation and blood cult.

(Signed)

Richard S. Coblenz, M. D.

19

(Address)

Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Accomac Va.

DATE OF BURIAL

July 9th 1920

20 UNDERTAKER

Leo S. Cook

ADDRESS

North & Hartford.

1044576

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 44576

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 265-4 Florence ST. 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 265-4 Florence St. Life Insurance yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

Caucasian5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH

April 17, 1920
(Month) (Day) (Year)

7-AGE

2 yrs. 18 mos. 18 da. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

9-BIRTHPLACE, (State or Country),

Balto md

10-NAME OF FATHER,

Charles Williams

11-BIRTHPLACE OF FATHER

(State or Country), md

12-MAIDEN NAME OF MOTHER

Lizzie Bonn

13-BIRTHPLACE OF MOTHER

(State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Williams(Address) 265-4 Florence

15-

Filed JUL 7 - 1920

ROBERT E. KAUTER

191

BALTIMORE, MARYLAND

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

7 5, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

7/2 1920, to 7/5 1920,that I saw him alive on 7/5 1920,and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Dr. Carter - internal
with degeneration
(Duration).....yrs.....mos.....da.

CONTRIBUTORY

(Secondary)

(Duration).....yrs.....mos.....da.

(Signed) Wm. R. Carter M. D.7/6, 1920 (Address) 2115 Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Albans

DATE OF BURIAL,

July 20

20-UNDERTAKER

Edw. RinggoldADDRESS July 20

CAUSE OF DEATH in plain terms, so that it may be plain to all. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

2 44577

79 2 44577

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. Mt. Holly Inn,

ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aaron Maass,

(Residence in Baltimore: No. 2336 Eutaw Place

St. 47 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED Married, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH Nov. 15th., 1849.
(Month) (Day) (Year)

7-AGE 70 yrs. 6 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work Wholesale
(b) General nature of industry, business, or establishment in which employed (or employer) Lace & Silks,

9-BIRTHPLACE (State or country)

Germany,

PARENTS

10-NAME OF FATHER Abraham Maass,

11-BIRTHPLACE OF FATHER Germany,
(State or country)

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER Germany,
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. Maass,

(Address) 2336 E.P.

15. JUL 7 - 1920 ROBERT E. KRAUTER
Filed 191 Barial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 6th, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1918 to July 6, 1920,
that I saw him alive on July 4th, 1920,
and that death occurred, on the date stated above, at 11:30 m.
The CAUSE OF DEATH* was as follows:

Valvular Heart Disease
Mitral Regurgitation

(Duration) 3 yrs. mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Thomas H. Stearns M. D.
July 6th, 1920 (Address) 905 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

St. Louis Cemetery July 8, 1920
David Sordheim 1180 N. Royal Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 Stiles)ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah B. Keatts(a) RESIDENCE. NO. 1019 Stiles

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds.ST. 3 WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) May, 29th, 19207 AGE
Years Months Days
===== 1 16
If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.10 NAME OF FATHER Wm. R. Keatts11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. Carolina12 MAIDEN NAME OF MOTHER Lorence M. Sheridan13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md.14 Informant Wm. R. Keatts
Robert E. Leaster
Registrar
Filed JUL 7 1920
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July, 6th, 192017 I HEREBY CERTIFY, That I attended deceased from July 2, 1920, to July 6, 1920,
that I last saw him alive on July 6, 1920,
and that death occurred, on the date stated above, at 6 m.The CAUSE OF DEATH^a was as follows:MarasmusCONTRIBUTORY (Secondary) Stomach & Intestines
(duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Valentini, M. D.

1601 (Address)

^aState the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery7/7

1920

20 UNDERTAKER

ADDRESS

C. F. Evans & Son - 113 W. Mt. Royal Ave.

REASON FOR DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates. CAUSE OF DEATH is very important.

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

244579

64244579

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Lexington & Pearl) ST.: 5 WARD) REGISTERED No. C.....
2-FULL NAME Thomas J. Byrnes
(Residence in Baltimore: No. Lexington & Pearl St. 3 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)
6-DATE OF BIRTH, Oct., 15th., 1862
(Month) (Day) (Year)
7-AGE, 57 yrs., 5 mos., 21 ds. If LESS than 1 day,hrs. or....min.?
8-OCCUPATION.
(a) Trade, profession, or particular kind of work, Ticket Taker
(b) General nature of industry, business, or establishment in which employed (or employer), Bay Shore Park

9-BIRTHPLACE, (State or Country), Balto. Md.
PARENTS.
10-NAME OF FATHER, Peter Byrnes
11-BIRTHPLACE OF FATHER (State or Country), Ireland
12-MAIDEN NAME OF MOTHER, Mary E. McHeive
13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Theresa M. Byrnes
(Address) 421 W. Sanatoga St.

15- JUL 7-1920 ROBERT A. KRAUTER
Filed 191 Barial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July, 6th., 1912
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said inquest and that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral apoplexy
a few hours
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) arteriosclerosis
(Duration) yrs. mos. ds.
(Signed) H. J. Gorman M. D. (Coroner.)
7-7, 1912 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place In the
of death....yrs.....mos.....ds. State....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral DATE OF BURIAL, 7/6, 1920
20-UNDERTAKER C. F. Evans & Son 116 W. St. Royal Ave. ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Mary J. Fuhrman

6 DATE OF BIRTH (month, day, and year)

Nov. 27-1841

7 AGE

78

Years

7

Months

Days

9

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stone Masonry

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired 4 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pennsylvania

10 NAME OF FATHER

Henry Fuhrman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

Emma Sharpe

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pennsylvania

14

Informant (Address)

Oliver P. Fuhrman 1207 Morning Ave

15

JUL 7 - 1920

ROBERT E. KAUFER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 6 1920

17

I HEREBY CERTIFY, That I attended deceased from

Aug 1st 1919, to July 6th 1920.

that I last saw him alive on July 6th 1920.

and that death occurred, on the date stated above, at 7:40 p.m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia (typo state)

CONTRIBUTORY (Secondary)

Prostatitis, nephritis, arteriosclerosis, Syphilis, Catarrh of Larynx

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. G. L. L. L.

19 20 Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mary's Hospital

July 9 1920

20 UNDERTAKER

ADDRESS

Grace L. Lurgeson

363 Falls Rd

1044581

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044581

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Grace Court ST. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anastazy Szymanski

(a) RESIDENCE. No. 1416 Grace Court ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year) May, 1-19

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 1 1 5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

"

(c) Name of employer

"

9 BIRTHPLACE (city or town) (State or country)

Curtis Bay,

10 NAME OF FATHER Jakim Szymanski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Curtis Bay

12 MAIDEN NAME OF MOTHER Mary. Stankiewicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Curtis Bay

14 Informant Jakim Szymanski

(Address) Curtis Bay

15 JUL 7-1920

BIRTH & DEATH

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1920

17 I HEREBY CERTIFY, that I attended deceased from July 1, 1920, to July 7, 1920,

that I last saw her alive on July 6, 1920,

and that death occurred, on the date stated above, at 4 H m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Dehydration

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) J. H. Jones, M. D.

, 19 (Address) 7340 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Cross Church 7/7 1920

20 UNDERTAKER ADDRESS

J. H. Jones 1618 Eastern

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Russell St. Mt. Vernon* ST.; *45* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Bates Woods*(Residence in Baltimore: No. *Russell St. Mt. Vernon* St.; *30* yrs., *30* mos., *30* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH.

Unknown, *1867* (Month) (Day) (Year)

7-AGE.

53 yrs., *30* mos., *30* ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Butler*9-BIRTHPLACE, (State or Country), *N.C.*10-NAME OF FATHER, *Jim Perry*11-BIRTHPLACE OF FATHER (State or Country), *N.C.*12-MAIDEN NAME OF MOTHER *Lucella Woods*13-BIRTHPLACE OF MOTHER (State or Country), *N.C.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert B. Trautner*(Address) *106 N. Biddle*

JUL 7-1920

Filed....., 191.....

ROBERT B. TRAUTNER

Burial Firm Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 6, *1920* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *about May 15* 191*9*, to *July 6* 192*0*,that I saw him alive on *July 2* 192*0*,and that death occurred, on the date stated above, at *3 a.* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis..... (Duration) *1* yrs., *30* mos., *30* ds.CONTRIBUTORY (Secondary) *Pulmonary Tuberculosis*..... (Duration) *1* yrs., *30* mos., *30* ds.(Signed) *Robert B. Trautner* M. D......, 191*9*. (Address) *6 N. Perry*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs., *30* mos., *30* ds. In the State..... yrs., *30* mos., *30* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Trinity Church*DATE OF BURIAL, *7/7*, 192*0*20-UNDERTAKER, *Samuel H. Hensley & Son*ADDRESS *106 N. Biddle*

CAUSE OF DEATH IN PRINT TERMS on back of certificate. important. See instructions on back of certificate.

1044583. HEALTH DEPARTMENT—CITY OF BALTIMORE 1044583

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *St. Joseph Hospital* ST. 10 WARD)
2-FULL NAME *Lillian A. Bridge*
(Residence in Baltimore: No. *717 N. Asquith* St.; yrs., *25* mos. *11* ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married* (Write the word.)
6-DATE OF BIRTH, *August 10, 1895*
(Month) (Day) (Year)

7-AGE, *25* yrs., *11* mos., *5* ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER, *John M. Winter*

11-BIRTHPLACE OF FATHER (State or Country), *Baltimore*

12-MAIDEN NAME OF MOTHER, *Wilmina Schaffer*

13-BIRTHPLACE OF MOTHER (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *J. M. Bridge*

(Address), *717 N. Asquith St.*

15- JUL 7 - 1920 ROBERT E. KAUTER

Filed JUL 7 - 1920 191... Burial Permit Office

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 5, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereof and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns, clark's campfire from bon fire.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. M. J. J. J.* M. D.

2-6-186, 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer Cem.* DATE OF BURIAL, *7-9-1920*

20-UNDERTAKER, *Robert Brooks & Son* ADDRESS *17 S Calhoun St*

N. B.—Every item of information should be carefully checked, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

1044584

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044584

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Md. Genl. Hosp.

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Talbott

(a) RESIDENCE. No.

23 E. Collington Ave.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Lys yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 6/20.

7 AGE

Years

Months

Days

If LESS than 1 day, 23 hrs. or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Medford Talbott

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Julia Crockett

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

14

Informant (Address)

Medford Talbott, 23 E. Collington Ave.

15

JUL 7 - 1920

ROBERT E. LEAUTEY, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 6 1920.

17

I HEREBY CERTIFY, That I attended deceased from

July 5, 1920, to July 6, 1920,

that I last saw him alive on July 6, 1920,

and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage (Thrombotic purpura).

(duration) yrs. mos. 6 mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Fred B. Smith, M. D.

, 19 (Address) W. B. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenwood Cemetery July 7 1920

20 UNDERTAKER

ADDRESS

Robt J. Turner 1442 E. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

1044585- HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 1044585-
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 254 J. Bouldin ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Henry A. Rickewald

(a) RESIDENCE. No.

254 J. Bouldin

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Maria Rickewald

6 DATE OF BIRTH (month, day, and year)

Aug. 8/1850

7 AGE

70

Years

Months

Days

IF LESS than 1 day, hrs. or min.

2 28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Andrew Rickewald

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Maria m. Kraft

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mrs. Frank Wells 254 J. Bouldin St.

15

JUL 7 - 1920

ROBERT S. KAUFMAN

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1920

17

I HEREBY CERTIFY, That I attended deceased from June 2, 1920, to July 6, 1920, that I last saw him alive on July 2nd, 1920, and that death occurred, on the date stated above, at 4 P. m. The CAUSE OF DEATH* was as follows:

arterio sclerosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Arterio Lungs

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. L. Tumbleson M. D.

76, 1920 (Address) 2013 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Schwartz Cemetery

Jul 9 1920

20 UNDERTAKER

ADDRESS

Geo. Limbach & Co.

647 N. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

1044586

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2516 W. Baltimore

ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Nettie Franklin

(a) RESIDENCE. NO. 2516 W. Balto.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

(HUSBAND or WIFE of)

John Franklin

6 DATE OF BIRTH (month, day, and year)

April 22nd 1856

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

64

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Frederick Co., Md.

10 NAME OF FATHER

John Kaiser

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany.

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

John Franklin
2516 W. Balto. St.

15

Filed

JUL 7-1920

ROBERT E. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

7/6

1920

17

I HEREBY CERTIFY, That I attended deceased from

June 5th, 1920, to July 6th, 1920,

that I last saw her alive on July 6th, 1920,

and that death occurred, on the date stated above, at 3:15 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease, associated with Arterio-Sclerosis & Paralysis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Endo-carditis & Myo-carditis

(duration) unknown - yrs. mos. ds.

15 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. & Laboratory Examine

(Signed)

B. W. H. Shreve, M. D.

, 19

(Address)

1206 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Frederick Md. Mt. Olivet July 10, 1920

20 UNDERTAKER

ADDRESS

F. A. Krause & Son 703 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly transcribed. See instructions on back of certificates.

141084
44587

HEALTH DEPARTMENT—CITY OF BALTIMORE

44587

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Colles Hopkins Hospital* ST.: *22* WARD)

2-FULL NAME

Edward Beard

(a) RESIDENCE. NO.

506 W. Conway St.

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. *Life* mos. *1*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

+

6 DATE OF BIRTH (month, day, and year)

Nov 2, 1900

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

19

8

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt. Maryland

10 NAME OF FATHER

Charles Beard

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Delia Fann.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

J. H. H. Beards

15

File

JUL 7-1920

ROBERT E. KAUFER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 5, 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 2, 1920, to July 5, 1920

that I last saw him alive on *July 5, 1920*

and that death occurred, on the date stated above, at *3:30 P. m.*

The CAUSE OF DEATH* was as follows:

Lung abscess

(duration) *8* yrs. *8* mos. *8* ds.

CONTRIBUTORY (Secondary)

Cerebral embolus

(duration) *24* yrs. *24* mos. *24* ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Yes Date of *June 11, 1920*

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed) *W. H. H. H.* M. D.

, 19 (Address) *John Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery July 8, 1920

20 UNDERTAKER

ADDRESS

F. A. Krause & Son 703 Hanover

CAUSE OF DEATH is given in plain terms, so that it may be understood by all. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Unknown

(Month) (Day) (Year)

7-AGE,

65 yrs. 7 mos. — ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Russia

10-NAME OF FATHER,

Philip Garonzik

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Moses B. Garonzik

(Address)

1802 N. Broadway

15-

JUL 7 - 1920

ROBERT E. KAUFER

BRIEF STATEMENT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from June 12 1920, to July 6 1920, that I saw him alive on July 3 1920, and that death occurred, on the date stated above, at 4:10 m.

The CAUSE OF DEATH* was as follows:

Valv. Dis. of Heart (Initial)

CONTRIBUTORY (Secondary)

(Duration)

yrs.

3 mos. — ds.

(Signed).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Hebrew Haring Run

20-UNDERTAKER

Max Simon

DATE OF BURIAL,

July 7, 1920

ADDRESS

1117 E Balto st

CAUSE OF DEATH IN PAIR TERMS, so that it may be important. See instructions on back of certificate.

N. B.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C.

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Single

6-DATE OF BIRTH,

Unknown, 1 (Month) (Day) (Year)

7-AGE,

28 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUL 7 - 1920

191. ROBERT E. KRATZER Registrar.

Burial Permit 0107

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH,

July 5, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic fall in airplane (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Signed) J. M. J. (Coroner.) M. D. 7-7, 1920 (Address) M. E. Lee

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ... Howell Michigan

19-PLACE OF BURIAL OR REMOVAL,

Howell Mich

20-UNDERTAKER J. L. Lumsden & Bro

DATE OF BURIAL,

July 7, 1920

ADDRESS 1147 E Balto St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. Place of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044590

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

91 ✓ 1044590

1 PLACE OF DEATH
CITY OF BALTIMORE (No. 1418 Central St. 24 WARD)
2-FULL NAME Theresa Zimmer
(Residence in Baltimore: No. 1418 Coville Dr. St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female
4-COLOR OR RACE white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Single

6-DATE OF BIRTH April 15, 1919.
(Month) (Day) (Year)

7-AGE 1 yrs. 2 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country) Baltimore Md

PARENTS
10-NAME OF FATHER Martin Zimmer
11-BIRTHPLACE OF FATHER Austria Hungary
12-MAIDEN NAME OF MOTHER Theresa Smith
13-BIRTHPLACE OF MOTHER Austria Hungary

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martin Zimmer
(Address) 1418 Coville Dr.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 6, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 20, 1919, to July 6, 1920, that I saw her alive on July 5, 1920, and that death occurred, on the date stated above, at 11:30 am.
The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) yrs. mos. 16 ds

Contributory (SECONDARY)
(Signed) Thos A Stevens M. D.
July 6, 1920 (Address) 2866 Keeford Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Holy Cross Cemetery
DATE OF BURIAL July 7, 1920

20-UNDERTAKER John J. Foley
ADDRESS 1318 E. 7th St.

15. JUL 7-1920 ROBERT F. KRAUTER
Burial Permit

REGISTERED No. C

CITY OF BALTIMORE: (No. *St. Vincent's Infant Hosp.* ST. *4* WARD)

2-FULL NAME

(Residence in Baltimore: No. 1401 Dunsen St. St.; yrs. 1 mos. 10 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

MEDICAL CERTIFICATE OF DEATH.

4-COLOR OR RACE.

5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

C-DATE OF BIRTH.

..... May 27, 1970
(Month) (Day) (Year)

7-AGE.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

BIRTHPLACE.

(State or Country),

10-NAME OF FATHER.

11-BIRTHPLACE
OF FATHER

**12-MAIDEN NAME
OF MOTHER**

13-BIRTHPLACE
OF MOTHER
(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address) 1401 Duran St

15-

1.7 - 1920 Robert P. Harrison,

Registrar.

~~Burial Permit Clerk.~~

16-DATE OF DEATH:

....., 1970
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
May 27, 1920, to July 5, 1920,
that I saw her alive on July 5, 1920,
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Euterpes "Acute"
Chickadee
(Duration).....yrs.....1 mos.....da

CONTRIBUTORY
(Secondary)

(Duration) yrs. 1 mos. ds.
(Signed) *Wm. H. Lawrence* M. D.
May 5, 1920 (Address) *1501 McChesney*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted,
if not at place of death?.....

Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Wash.*)ST. *15* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *Beth Rose Katz*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *1* mos. *19* ds.ST. *15* WARD. (If nonresident give city or town and State)

How long in U. S., if of foreign birth?

yrs. *1* mos. *19* ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *7/7* 19 *20*17 I HEREBY CERTIFY, That I attended deceased from *6/80* 19 *20*, to *July 7* 19 *20*.that I last saw him alive on *July 7* 19 *20*.and that death occurred, on the date stated above, at *home*.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis - Emphysema(duration) yrs. *1* mos. ds.

CONTRIBUTORY (Secondary)

(duration)

yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

7/7 19 *20* Address) *Mary Wash.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

14 Informant (Address)

Robert P. Harrison,

Registrar

15

JUL 7-1920

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates. TION is very important.

PARENTS

10 NAME OF FATHER *Israel Katz*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER *Rosa*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST.: *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *George M. Taylor*(a) RESIDENCE. NO. *Greenville, S. C.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. *5*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Eliza A Taylor*6 DATE OF BIRTH (month, day, and year) *Dec 15 1897*7 AGE *22* Years *6* Months *21* Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *South Carolina* (State or country)10 NAME OF FATHER *Washington Taylor*11 BIRTHPLACE OF FATHER (city or town) *S. C.* (State or country)12 MAIDEN NAME OF MOTHER *Nancy Cunningham*13 BIRTHPLACE OF MOTHER (city or town) *S. C.* (State or country)14 Informant *Hospital Person* (Address) *H. H.*15 *Robert P. Harrison,* Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 6 1920*

17 I HEREBY CERTIFY, That I attended deceased from

July 3, 19*20*, to *July 6*, 19*20*that I last saw him alive on *July 6*, 19*20*,and that death occurred, on the date stated above, at *10:45* P. M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency(duration) yrs. *11* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

*S. C.*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *William S. Miller*, M. D.(Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Greenville S. C.**July 7 1920*

20 UNDERTAKER

John O. Mitchell

ADDRESS

1241 W. Fayette

CAUSE OF DEATH in plain terms, so that it can be understood by the layman. See instructions on back of certificates.

JUL 7-1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST.; 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Siebert(a) RESIDENCE, No. 1010 S. Potomac St.
(Usual place of abode)ST. 1 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18557 AGE 65 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)14 Informant Hospital Records
(Address) New City Hospital.15 Filed Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 192017 I HEREBY CERTIFY, That I attended deceased from August 9, 1910 to July 7, 1920
that I last saw him alive on July 6, 1920
and that death occurred, on the date stated above, at 5:00 A.M.
The CAUSE OF DEATH* was as follows:Syngonmyelia(duration) 10 yrs. mos. ds.CONTRIBUTORY
(Secondary)(duration) 10 yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? No special test(Signed) R. H. Horman, M. D.July 7, 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Matthew's Cem.

DATE OF BURIAL

July 8 1920

20 UNDERTAKER

Gorkle & Gorkle

ADDRESS

1739 E. Egan

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates. This is very important.

JUL 7-1920

Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH S. E. Cor. Fayette
CITY OF BALTIMORE: (No. & Pulaski Sts.,

REGISTERED NO. C

ST.: 70 WARD

(If death occurred in a
hospital or institution,
give its NAME instead
of street and number and
all out No. 18.)

2-FULL NAME Robert L. Paul

(Residence in Baltimore: No. Melvin Ave., Catonsville

St.: 40 yrs., 5 mos., 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married
(Write the word.)

6-DATE OF BIRTH, Jan. 21, 1880
(Month) (Day) (Year)

7-AGE, 40 yrs., 5 mos., 15 ds.
If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: Teacher of
(a) Trade, profession, or particular kind of work..... Harmony
(b) General nature of industry, busi- Peabody Conservatory
ness, or establishment in which of Music
employed (or employer).....

9-BIRTHPLACE,
(State or Country), Baltimore, Md.

10-NAME OF FATHER, Thomas K. Paul

11-BIRTHPLACE OF FATHER, Baltimore, Md.
(State or Country),

12-MAIDEN NAME OF MOTHER Eliza J. Lawrenson

13-BIRTHPLACE OF MOTHER, Boston, Mass
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary L. Paul
Melvin Ave., Catonsville
(Address).....

15-

Robert P. Harrison,
191.....
Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 6, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 14th 1920, to July 6th 1920, that I saw him alive on July 5th 1920, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Surgical shock, following
gastro-enterostomy & breast
operation of adhesions, for functional
ileus (Duration) 2 yrs., 2 mos., 15 ds.

CONTRIBUTORY (Secondary) Surgical shock

12 hrs. after operation, and (Duration) 12 hrs., 2 mos., 15 ds.

(Signed) J. R. Leonard M. D.

July 6, 1920 (Address) Bon Secours Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 21 ds. In the 40 yrs. — mos. — ds. State

Where was disease contracted,
if not at place of death?

Former or usual residence Melvin Ave. - Catonsville, Md.

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery

DATE OF BURIAL,

7/8, 1920

20-UNDERTAKER

Henry W. Mears & Son 805 N. Calvert

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,

(Write the word.)

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

IF LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

5/25 1920, to 5/25/20 191

that I saw him alive on 5/25/20 191

and that death occurred, on the date stated above, at 12:45 m.

The CAUSE OF DEATH* was as follows:

Asthma
(Six month fortus)
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.
(Signed) J. H. G. M. D.
5/25/20 (Address) 633-5-3rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH IN plain terms on back of certificate. important. See instructions on back of certificate.

JUL 7 - 1920

Robert P. Harrison,

Burial Permit Clerk Registrar.

G. H. G.

D. 44597

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44597

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* ST. *19* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Francis Powell*(a) RESIDENCE. No. *228 N Vincent* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *23* yrs. *1* mos. *1* ds. How long in U. S., if of foreign birth? *23* yrs. *1* mos. *1* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F.* 4 COLOR OR RACE *Black* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 3 1897*7 AGE Years *23* Months *1* Days *1* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Domestic Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *William Smith*9 BIRTHPLACE (city or town) (State or country) *Ad*10 NAME OF FATHER *Francis*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ad*12 MAIDEN NAME OF MOTHER *Mr. Henderson*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ad*

14

Informant *Josephine Joanne* (Address) *228 N Vincent St*

15

Filed *7-19-1920* Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *7-4-1920*17 I HEREBY CERTIFY, That I attended deceased from *June 27, 1920*, to *July 4, 1920*, that I last saw him alive on *July 3, 1920*, and that death occurred, on the day stated above, at *5:30 P.M.*

The CAUSE OF DEATH* was as follows:

Tuberculosis General milium(duration) yrs. *7* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Uncertain*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Raymond W. Rosenthal*19 (Address) *Mary Ho*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER *Brown & Island*ADDRESS *114 St*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

D 44598

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Armedad Johnson.

(a) RESIDENCE. NO.

Burkville Virginia

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred (?) yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 18627 AGE 58 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Seaboard

(b) General nature of industry, business, or establishment in which employed (or employer)

at factory Sparrows Point

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Leemingburg Va.

10 NAME OF FATHER

Tyler Tisdale

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Leemingburg

12 MAIDEN NAME OF MOTHER

Glennora Craig

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Leemingburg Va.

14

Informant (Address)

Carrie G. Raden 1027 W. Washington St.

15

File

JUL 8-1920ROBERT F. KRAUTERBurial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 19 20

17 I HEREBY CERTIFY, That I attended deceased from

July 2 19 20, to July 6 19 20that I last saw him alive on July 6 19 20and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Syphilitic Meningitis(duration) yrs. (?) mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical Exam. & Laboratory(Signed) C. Wilbur Orlewalt M. D., 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

mt AuburnJuly 8 19 20

20 UNDERTAKER

ADDRESS

Joseph A. Farrell2319 Division

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

44599

CERTIFICATE OF DEATH.

28-44599

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5086441 ST.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 5086441 St.; 2 yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Caucasian

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)

Single

6-DATE OF BIRTH,

Dec 1917 (Month) (Day) (Year)

7-AGE,

2 yrs., 8 mos., ds. If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... (b) General nature of industry, business, or establishment in which employed (or employer)...

Infant

9-BIRTHPLACE, (State or Country),

Bath, Cts.

PARENTS.

10-NAME OF FATHER,

John

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Mary Tucker

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

JUL 8 - 1920

ROBERT B. BRAUTER

Filed..... 191.....

Burial Permitted

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 6th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 18, 1920, to July 6th, 1920, that I saw him alive on July 30, 1920, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Tubercular Pneumonia

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds. (Signed) A. R. Ellis, M. D. 7/7, 1920 (Address) 524 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state: (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn Cemetery, July 8, 1920

20-UNDERTAKER,

Wm. H. Hensley, 11 Bradlee

CAUSE OF DEATH IN POINT OF VIEW. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *613 Archer St* ST.; *7th* WARD)

2-FULL NAME

(Residence in Baltimore: No. *613 Archer St* St.; *1* yrs., *10* mos., *—* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*Coscolod*5-SINGLE, *Widow*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

April (Month) *30* (Day), *1878* (Year)

7-AGE,

62 yrs., *2* mos., *5* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*House Work**House Work*

9-BIRTHPLACE,

(State or Country),

Born in Baltimore City

10-NAME OF FATHER,

Benjamin Loos

11-BIRTHPLACE OF FATHER

(State or Country),

Born in Baltimore

12-MAIDEN NAME OF MOTHER

Lidian Oliver

13-BIRTHPLACE OF MOTHER

(State or Country),

Born in Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

(Address),

15-

Filed

JUL 8-1920

ROBERT E. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July (Month) *5* (Day), *1920* (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1, 19*20*, to *July 5*, 19*20*,that I saw her alive on *July 4*, 19*20*and that death occurred, on the date stated above, at *7:40 p.m.*

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *J. H. Barton* M. D.*7/7/20*, 19*20* (Address) *888 St. Paul*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Int-Burial in

DATE OF BURIAL,

July 8, 1920

20-UNDERTAKER

Mrs R A Elliott

ADDRESS

725 Ashland

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1213 Rutland* ST.: *8* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred *45* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Henry Greene

6 DATE OF BIRTH (month, day, and year)

Aug 22 1899

7 AGE

80 Years *10* Months *15* Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Henry Greene 1213 Rutland

15

*JUL 8-1920**ROBERT F. KRAUTER**Barred Entry State*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 7 1920

17

HEREBY CERTIFY, That I attended deceased from

June 25 1920, to *July 7 1920*that I last saw him alive on *July 6 1920*and that death occurred, on the date stated above, at *8 15* a.m.

The CAUSE OF DEATH* was as follows:

Fracture of femur

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*at home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *yes*

(Signed)

E. O. Stoner, M. D.

19 (Address)

1501 E. Enoch

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Carmel July 9 1920

20 UNDERTAKER

ADDRESS

*Louis's Heerman 22 E. Pratt**way*

CAUSE OF DEATH is printed in plain text on back of certificates. See instructions on back of certificates.

(Over)

D 44602.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44602.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

1629 Edmondson Ave.

WARD) 19

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lydia Rebecca Chance

(a) RESIDENCE

No. 1629 Edmondson Ave.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND or (or) WIFE of

Wm. T. Chance

6 DATE OF BIRTH (month, day, and year)

Oct 28 1834

7 AGE

85

Years

8

Months

9

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Delaware

10 NAME OF FATHER

Benj. E. Hale

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Delaware

12 MAIDEN NAME OF MOTHER

Lydia Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Delaware

14

Informant (Address)

Anne E. Hale 1629 Edmondson Ave.

15

Filed

JUL 8 1920

ROBERT E. KAUFER

Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 7 1920

17

I HEREBY CERTIFY, that I attended deceased from July 1 - 1920, to July 7 1920, that I last saw him alive on July 7 - 1920

and that death occurred, on the date stated above, at 11:30 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Angina Pectoris

(duration) - yrs. - mos. - ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. B. Truman, M. D.

, 1920 Address)

412 Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Smymna Del.

July 9 1920

20 UNDERTAKER

ADDRESS

Wm. J. Tucker Sons North Pa

1044603. HEALTH DEPARTMENT—CITY OF BALTIMORE 1044603.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 Mosher St ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Marion Jones

(a) RESIDENCE. No. 1225 Mosher ST. 16 WARD. 1044603.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 65 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J Jones

6 DATE OF BIRTH (month, day, and year) Aug. 1, 1854

7 AGE Years 65 Months 11 Days 25 H LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Large carpenter

(c) Name of employer McDonnell & Co

9 BIRTHPLACE (city or town) Baltimore
(State or country)

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Not known

12 MAIDEN NAME OF MOTHER Henrietta Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) London, Va

14 Informant Wife
(Address) 1225 Mosher St

15 JUL 8 - 1920 ROBERT E. KAUFER
Burial Permit 1044603

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 19 20

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1920, to July 6, 1920, that I last saw him alive on July 6, 1920, and that death occurred, on the date stated above, at 6 4 m. The CAUSE OF DEATH* was as follows:
Acute gastro-enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) W. R. Risher, M. D.

7/7, 1920 (Address) 619 N. Carrollton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Olivet Cem July 9 1920

20 UNDERTAKER Wm. J. Trickett & Sons ADDRESS North St

Information should be carefully supplied. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of

1044604 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044604

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5403 Harford Ave

ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary E. Boone

(a) RESIDENCE. No. 5403 Harford Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 1 mos. 29 ds.

How long in U. S. If of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of or WIFE of

J. H. S. Boone

6 DATE OF BIRTH (month, day, and year)

May 7 1864

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

56

1

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt. Md.

10 NAME OF FATHER

William S. Maule

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mary Knittel

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa.

14

Informant (Address)

Mr. J. H. S. Boone 5403 Harford Ave

JUL 8 - 1920

ROBERT E. KRAUTER Registrar Social Pathologist

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 6 1920

17

I HEREBY CERTIFY, That I attended deceased from

Nov 26 1919, to July 6 1920.

that I last saw her alive on July 5 1920.

and that death occurred, on the date stated above, at 11:05 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Intestinal Regurgitation & Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Clara S. Sinner, M. D.

July 6 1920 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Resurrection Cemetery

July 9 1920

20 UNDERTAKER

ADDRESS

Henry Horch & Son

1301 E. Eager

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

1044605 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1059 Harford Ave ST. 10 WARD)

2-FULL NAME

(a) RESIDENCE. No. 1059 Harford Ave ST. 10 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

(or) WIFE of

HUSBAND of William Tinker

6 DATE OF BIRTH (month, day, and year) May 21 1886

7 AGE Years 64 Months 1 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Adams Co. Pa. (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mr. William Tinker (Address) 1059 Harford Ave

15 JUL 8 - 1920 ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 20, 1920, to July 7, 1920, that I last saw him alive on July 6, 1920,

and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Cephalosia

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. S. Brown M. D.

July 7, 1920 Address 1504 E. Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lorraine Cemetery

July 10 1920

20 UNDERTAKER

ADDRESS

Henry Stock Son

1301 E. Bay View

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 Gorsuch Ave. 9 ST.)

2-FULL NAME Elizabeth Kness

(a) RESIDENCE. NO. 1724 Gorsuch Ave. ST.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth John Kness

6 DATE OF BIRTH (month, day, and year) May 24 1843

7 AGE Years 77 Months 1 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant M. Conrad Kness (Address) 1724 Gorsuch Ave.

15 JUL 8 - 1920

ROBERT B. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1920

17 I HEREBY CERTIFY, That I attended deceased from June 17 1920, to July 8 1920, that I last saw her alive on July 8 1920, and that death occurred, on the date stated above, at 5:00 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis, Cardiac insufficiency, edema & infarction of lung

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary analysis

(Signed)

7-8-1920 (Address)

1707 N. Caroline St. M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Sondow Park Cemetery

20 UNDERTAKER

Henry Horck Sen

DATE OF BURIAL

July 10 1920

ADDRESS

1301 E. Egle Ave.

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

1044607 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Church Home Infirmary

CITY OF BALTIMORE: (No.

126 N. Broadway

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mr. Wm. R. C. Roe

(a) RESIDENCE. NO.

3604 Park Heights Ave

ST.

WARD.

Baltimore

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

38 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND or (or) WIFE of

Clara M. Roe

6 DATE OF BIRTH (month, day, and year)

30 Aug 1861

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

58

11

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Manufactures Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

selling

(c) Name of employer

Roe Pfeiffer Co.

9 BIRTHPLACE (city or town) (State or country)

Roe, Guyanane Co. Ind.

10 NAME OF FATHER

Wm. C. Roe

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary E. Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

C. E. Short 3604 Park Heights Ave

15

Filed

JUL 8-1920

ROBERT E. FRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 6 - 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 20, 1920, to July 6, 1920, that I last saw him alive on July 6, 1920, and that death occurred, on the date stated above, at 4:07 PM.

The CAUSE OF DEATH* was as follows:

- ① Mitral Insufficiency
- ② Chronic Nephritis
- ③ Renal Effusion & Gall Stones

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 21, 1920

Was there an autopsy? no

What test confirmed diagnosis? Exam. & lab. tests.

(Signed)

Walter S. Anderson M. D.

, 19

(Address)

Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Price's Mt.

July 9 1920

20 UNDERTAKER

A. S. Marshall 3539 Fall Road

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

10.44608

HEALTH DEPARTMENT—CITY OF BALTIMORE

186 1044608

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1 ST.)

WARD)

2-FULL NAME

(Residence in Baltimore: No. 2938 E Monument St.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs.,

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

ROBERT B. KRAUTER

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic injuries
fire cracker

CONTRIBUTORY (Secondary)

(Signed)

(Coroner)

1-1, 1920 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death....yrs....mos....ds. State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be given in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Church Home & Infirmary*
 CITY OF BALTIMORE: (No. *26 N. Broadway* ST.: *7* WARD)

2-FULL NAME *Mrs. Marie Korn*

(a) RESIDENCE. NO. *636 St. Stephen* ST.: _____ WARD. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred *14* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced *Widowed* of *Geo. H. Korn*
 (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Apr 27/89*
 7 AGE Years *31* Months *2* Days *10* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 7 1920*

17 I HEREBY CERTIFY, That I attended deceased from *July 6 1920*, to *July 7 1920*, that I last saw him alive on *July 7 1920*, and that death occurred, on the date stated above, at *7:15 a.m.*
 The CAUSE OF DEATH* was as follows:

Empyema.

CONTRIBUTORY (Secondary) *Endocarditis, mitral insufficiency*
acute nephritis (duration) yrs. mos. 28 ds. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Examination & Lab. tests.*
 (Signed) *Charles J. Anderson M.D.*

19 (Address) *Church Home & Infirmary*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

July 8 1920

20 UNDERTAKER

ADDRESS

Philip Henry

2016 Orleans

Burial Permit

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701, Tension)ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thomas H. Moody(a) RESIDENCE. NO. 701 Tension

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State) .

Length of residence in city or town where death occurred 2 yrs.

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored.

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan. 1, 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

160

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Thomas W. Moody

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Agnes Hollie

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md.

14

Informant (Address)

Mrs. Agnes Moody
701 Tension St.

15

Filed

JUL 8-19 1920ROBERT E. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 28, 1920, to July 7, 1920.that I last saw him alive on July 7, 1920.and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Dis-eolitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

acute myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Examination.

(Signed)

Charles H. Antold, M. D.

, 19 (Address)

221 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

CathedralJuly 9th 1920

20 UNDERTAKER

Samuel Ellinghill 36-22-23

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mrs. Kasp.*ST.: *22* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Helen Papilor*(a) RESIDENCE. NO. *211 S. Poca*

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *5/2/1911*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore*10 NAME OF FATHER *Anton Papilor*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Baltimore*12 MAIDEN NAME OF MOTHER *Elyse Stark*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Anton Papilor
211 S. Poca St.

15

Filed

JUL 8-1920

ROBERT A. HEATH

Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 7* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

July 4, 19*20*, to *July 7*, 19*20*.that I last saw him alive on *July 7*, 19*20*.and that death occurred, on the date stated above, at *12:15* p. m.

The CAUSE OF DEATH* was as follows:

Pneumothorax - Tuberculosis?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Lucas D. Ridgeley*, M. D.19 (Address) *Mrs. Kasp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross A. C. July 7 19*20*

20 UNDERTAKER

ADDRESS

John Greblinukas 425 S. Poca St.

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

1044612

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044612

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baltrus Astromskis(a) RESIDENCE. NO. 740 W. Lexington St.

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofCatherine Astromskis6 DATE OF BIRTH (month, day, and year) 18587 AGE 62 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)14 Informant Hospital Records(Address) New City Hospital.15 Filed JUL 8-1920 ROBERT A. ELLIOTT
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 192017 I HEREBY CERTIFY, That I attended deceased from
January 26, 1920, to July 6, 1920,that I last saw him alive on July 6, 1920,and that death occurred, on the date stated above, at 10:15 P.m.

The CAUSE OF DEATH* was as follows:

Generalized arterio-sclerosis
(no cerebral hemorrhage)(duration) 7 yrs. mos. ds.CONTRIBUTORY Senile dementia
(Secondary) (duration) 1 yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No special test.(Signed) R. H. ..., M. D.(Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy RedeemerJuly 10 1920

20 UNDERTAKER

ADDRESS

John G. G. ...745 S. ...

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3130 Harbor Road ST.; 9 WARD)

REGISTERED NO. C

2-FULL NAME

Ruth Elizabeth Hempfling

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 3130 Harbor Road St.; 16 yrs., 10 mos., 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

Single

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

August 27, 1903
(Month) (Day) (Year)

7-AGE,

16 yrs., 10 mos., 9 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

at school

9-BIRTHPLACE,

(State or Country),

Baltimore Md

10-NAME OF FATHER,

Henry Hempfling

11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore Md

12-MAIDEN NAME OF MOTHER

Emma M Magandt

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Hempfling(Address) 3130 Harbor Ave

15-

Filed

JUL 8 - 1920

ROBERT E KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 6, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 7, 1920, to July 6, 1920,that I saw her alive on July 6, 1920,and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus(Duration) 1 yrs., 10 mos., 9 ds.

CONTRIBUTORY

(Secondary)

Diabetic Coma(Duration) 8 hours(Signed) Frank J. Smith M. D.July 6, 1920 (Address) 1126 E Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 16 yrs., 10 mos., 9 ds. In the State 16 yrs., 10 mos., 9 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Druid Ridge Cemetery

DATE OF BURIAL,

July 9, 1920

20-UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E Monument St.

important. See instructions on back of certificate.

1044614 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4917 Eastern ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary S. Hutchins

(a) RESIDENCE. No. 4917 Eastern (Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry C Hutchins

6 DATE OF BIRTH (month, day, and year) Feb 14, 1860

7 AGE Years 61 Months 4 Days 26 If LESS than 1 day X hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home (b) General nature of industry, business, or establishment in which employed (or employer) house wife (c) Name of employer same

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

10 NAME OF FATHER J. Greenman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. Md.

12 MAIDEN NAME OF MOTHER Wenkelman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt. Md.

14 Informant Harry C Hutchins (Address) 4917 Eastern

15 JUL 8 - 1920 ROBERT A. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1920, to July 6, 1920, that I last saw her alive on July 5, 1920, and that death occurred, on the date stated above, at 1:00 p.m.

The CAUSE OF DEATH* was as follows:

Exhaustion
Uræmic Coma

CONTRIBUTORY (Secondary) Chronic Parenchymatous (duration) X yrs. X mos. 2 ds.

18 Where was disease contracted same If not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? General Sangu

(Signed) Dr. L. J. Greenman M. D.

July 6, 1920, 248 So 39 St (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mount Carmel Cem

20 UNDERTAKER

J. Herwig & Co

DATE OF BURIAL

July 9, 1920

ADDRESS

2008 Orleans

CAUSE OF DEATH is very important. See instructions on back of certificates.

1044615

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

50

1044615

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2538 E Baltimore St. ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John J. Rudolph.

(a) RESIDENCE. No. 2538 E Baltimore St. WARD. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of Margaret Rudolph
(or) WIFE of May 27th 1866

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
54	I	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

10 NAME OF FATHER John Rudolph
11 BIRTHPLACE OF FATHER (city or town). Germany
(State or country)
12 MAIDEN NAME OF MOTHER Barbara Kosseth
13 BIRTHPLACE OF MOTHER (city or town). Germany
(State or country)

14 Informant Walter T Schrodell
(Address) 2538 E. Baltimore St.

JUL 8 - 1920

ROBERT B. ELSTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6th 1920

17 I HEREBY CERTIFY, That I attended deceased from 1912, to July 6th 1920, that I last saw him alive on July 4, 1920, and that death occurred, on the date stated above, at 9 A.M. m.
The CAUSE OF DEATH* was as follows:

Pulmonary edema

(duration) yrs. mos. ds.
CONTRIBUTORY Diabetic Mellitus
(Secondary) (duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Kelly M. D.
, 1920 Address 60 Reed St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery
20 UNDERTAKER J. Herwig & Co

July 8 1920
ADDRESS 2008 Orleans

CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

840 Vine

ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Moranda Williams

(a) RESIDENCE. NO.

840 Vine

ST.: WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Addison Williams

6 DATE OF BIRTH (month, day, and year)

Sept. 11, 1861

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

58

9

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress.

(b) General nature of industry, business, or establishment in which employed (or employer)

Washing & Ironing

(c) Name of employer

Home Laundress.

9 BIRTHPLACE (city or town)
(State or country)

Annapolis, Md.

10 NAME OF FATHER

Charles Gibson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Annapolis, Md.

12 MAIDEN NAME OF MOTHER

Harriet Brogden

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Annapolis, Md.

14

Informant
(Address)Charles Gibson
840 Vine St.

15

JUL 8 - 1920

ROBERT B. KRAUTER

Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 7 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 2, 1920, to July 7, 1920,

that I last saw her alive on July 6, 1920,

and that death occurred, on the date stated above, at 5:51 A. M.

The CAUSE OF DEATH* was as follows:

Volvulus.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

840 Vine St.

Did an operation precede death? none Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed)

William H. Wright, M. D.

Address) 1209 Presbiterian St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Cemetery July 9 1920

20 UNDERTAKER

ADDRESS

George H. Holland 1631 Druid Hill Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 N. Part ST.; 6 WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. 24 N. Part St.; 6 yrs., 6 mos., 6 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH

July 7, 1869
(Month) (Day) (Year)

7-AGE

57 yrs., 6 mos., 6 ds.If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. house work
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Bohemia

10-NAME OF FATHER,

Joseph Bares

11-BIRTHPLACE OF FATHER (State or Country),

Bohemia

12-MAIDEN NAME OF MOTHER

Mary Cumat

13-BIRTHPLACE OF MOTHER (State or Country),

Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theresa Balok(Address) 24 N. Part St.

15-

JUL 8 - 1920

ROBERT B. KRAUTER

Filed

191.. Barist. Permit Stat.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 7, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 2 1920, to July 7 1920, that I saw her alive on July 7, 1920, and that death occurred, on the date stated above, at 12:20 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis
(Duration) 2 yrs., 6 mos., 6 ds.

CONTRIBUTORY (Secondary)

(Signed) Eugene L. Passano M. D.
July 7, 1920 (Address) 2314 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 6 yrs., 6 mos., 6 ds. In the State 6 yrs., 6 mos., 6 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Holy Redeemer
20-UNDERTAKERJuly 10, 1920
ADDRESS Frank Coachman

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 42V-N. Chapel ST.; 6 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 42V-N. Chapel St.; 10 yrs., 10 mos., 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

col.5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) widow

6-DATE OF BIRTH

Probably 1863 (Year)

7-AGE

57 yrs., 2 mos., 10 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....Housework
Domestic

9-BIRTHPLACE, (State or Country),

Virginia

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Forrest(Address) 904 Madison Ave.

15 JUL 8 - 1920

ROBERT B. KRAUTER

Filed

191

BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 6, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from about 183 1920, to 6 July 1920, that I saw he was alive on 31 1920, and that death occurred, on the date stated above, at 31 m.

The CAUSE OF DEATH was as follows:

My daughter
Robert
(Duration) 3 yrs., 10 mos., 10 ds.

CONTRIBUTORY (Secondary)

Robert
(Signed) Robert Forrest M. D.
7/7 1920 (Address) 42V-N. Chapel

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 10 yrs., 10 mos., 10 ds. In the State 10 yrs., 10 mos., 10 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Gravel Cemetery

DATE OF BURIAL,

July 8, 1920

20-UNDERTAKER

Chas & Bailey

ADDRESS

Jefferson St

important. See instructions on back of certificate.

1044619

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044619

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Lake Montebello

ST.:

9

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Sarah E Kidd

(Residence in Baltimore: No.

On Lake Montebello

St.: 5 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH,

July 23

(Month) (Day) (Year)

7-AGE,

65 yrs. 11 mos. 14 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

House wife

9-BIRTHPLACE,

(State or Country)

Baltimore Md

PARENTS.

10-NAME OF FATHER

James Mc Guffin

11-BIRTHPLACE OF FATHER (State or Country)

Ireland

12-MAIDEN NAME OF MOTHER

Caroline Kravon

13-BIRTHPLACE OF MOTHER (State or Country)

Philadelphia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Frank Kidd

(Address)

Charles Ave. Danvers, Md.

15-

JUL 8 - 1920

ROBERT E. KRAUTER

Filed..... 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 7

(Month)

(Day)

1920 (Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 4 1920, to July 7 1920,

that I saw her alive on July 7 1920,

and that death occurred, on the date stated above, at 10:50 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)

yrs. mos. ds.

CONTRIBUTORY (Secondary)

Coronary (Duration) yrs. mos. ds.

(Signed) H. Young Whitlock M. D.

July 7, 1920 (Address) 618 Gough Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cemetery

DATE OF BURIAL,

July 9, 1920

20-UNDERTAKER

Frank Lee Johnson

ADDRESS

Fullerton Md.

important. See instructions on back of certificate.

(Over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lesinsky(a) RESIDENCE. No. 1312 Rienoyd St. Locust Point. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) Russia
(State or country)10 NAME OF FATHER Frank Lesinsky11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)14 Informant Hospital Records
(Address) M.T.H.15 JUL 8 - 1920 ROBERT F. FRATER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 192017 I HEREBY CERTIFY, That I attended deceased from
December 14, 1919, to July 7, 1920,that I last saw him alive on July 6, 1920,and that death occurred, on the date stated above, at 5.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 20 yrs. 0 mos. 0 ds.CONTRIBUTORY
(Secondary)(duration) 0 yrs. 0 mos. 0 ds.18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George R. W. Kline, M. D.7-7-20 Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL 7/8 192020 UNDERTAKER W. J. SadowskiADDRESS 1618 Eastern

CAUSE OF DEATH is plain terms, so that the family may understand. See instructions on back of certificates. TION is very important.

44621 HEALTH DEPARTMENT—CITY OF BALTIMORE CERTIFICATE OF DEATH. 44621 X 104 8 44621

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* ST. *18* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary Frank*(a) RESIDENCE. NO. *Mary & Childs Hosp.* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *3*

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed

19

JUL 8-1920

Baltimore City Health Department

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *7/7* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

7/5 19*20* to *7/7* 19*20*that I last saw him alive on *7/7* 19*20*and that death occurred, on the date stated above, at *2:00* p. m.

The CAUSE OF DEATH* was as follows:

Chronic Gastro-Enteritis(duration) yrs. *2* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Edw. J. Ridge*

M. D.

7/7 19*20* (Address) *Mary Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St Patrick Ce**July 8* 19*20*

20 UNDERTAKER

Mr & Mrs M S Pink 12671 Prosser

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Sinclair(a) RESIDENCE. No. UnknownST. 26 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widower5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18387 AGE Years Months Days If LESS than 1 day, hrs. or min. 82

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.10 NAME OF FATHER Mathew Sinclair11 BIRTHPLACE OF FATHER (city or town) Baltimore, (State or country) Md.12 MAIDEN NAME OF MOTHER Elizabeth Fust13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) Md.14 Informant Hospital Records,(Address) New City Hospital.15 Filed 1920 19 Robert P. Harrison, Registrar

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 192017 I HEREBY CERTIFY, That I attended deceased from June 25, 1920 to July 5, 1920 that I last saw him alive on July 5, 1920 and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH* was as follows:

Generalized arterio-sclerosis (no cerebral hemorrhage)(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Enterocolitis (non-specific) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No special test(Signed) W. H. Harrison M. D.6-20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND.July 8 1920

20 UNDERTAKER

ADDRESS

Commissioner Health.

Per. Wm. F. WOODALL.

CAUSE OF DEATH is very important. See instructions on back of certificates.

10.44623

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.44623

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

(Coroner)

(Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly transcribed. See instructions on back of certificate.

UL 8-1920

D. 44624

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44624

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

439 S. Stricker

St.

19

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary Cassup

(Residence in Baltimore: No.

439 S. Stricker

St.; yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Dec

30

1856

7-AGE,

64

6

mos.

7

ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife
at home

9-BIRTHPLACE, (State or Country),

German Poland

10-NAME OF FATHER,

Martin Brzmkowski

11-BIRTHPLACE OF FATHER (State or Country),

German Poland

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

German Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joseph Cassup

(Address)

439 S Stricker St

15-

Robert P. Harrison,

Filed 1920

191

Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

6

1920

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis

CONTRIBUTORY (Secondary)

artery (Duration) 2 mos. ds.

(Signed) James M. Barton M. D.

(Coroner.)

July 7, 1920 (Address) 707 E. Chas St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer Cem.

DATE OF BURIAL,

July 8, 1920

20-UNDERTAKER

Lilly + Zeiler

ADDRESS

403 S. W. 1st St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *80-3rd Ave E. Brooklyn* ST. 25 WARD)

2-FULL NAME

(Residence in Baltimore: No. *80-3rd Ave E. Brooklyn* St.: *3* yrs., *3* mos. *23* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

M.

4-COLOR OR RACE,

*W.*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*

6-DATE OF BIRTH,

March 15th, 1917
(Month) (Day) (Year)

7-AGE,

3 yrs., *3* mos., *23* ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*Child*

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Rudolph Herman Haase

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Dora Brainer

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Rudolph H. Haase

(Address)

80-3rd Ave East Brooklyn

15-

Robert P. Harrison,

Filed.....

1920

191.....

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 8th, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

*July 3rd 1920, to July 8th 1920,*that I saw him alive on *July 7th 1920,*and that death occurred, on the date stated above, at *4 a. m.*

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

None

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

Geo. B. Davis
July 8, 1920 (Address) *211 Church St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Cross A.C. Co

DATE OF BURIAL,

July 10, 1920

20-UNDERTAKER

E. B. Harber

ADDRESS

115 E. West St.

important. See instructions on back of certificate.

D.44626

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.44626

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

839 Linden Ave. ST. 11

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Robert Smith

(a) RESIDENCE. NO.

839 Linden Ave. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

64 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Color

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Emma Smith

6 DATE OF BIRTH (month, day, and year)

Mar. 3-1856

7 AGE

64

Years

Months

4

Days

2

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

L

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Robert Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Fannie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Victoria Smith 839 Linden Ave

15

Filed

JUL 8-1920 Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 6

1920

17

I HEREBY CERTIFY, That I attended deceased from

March 1920, to July 6th 1920

that I last saw him alive on July 3, 1920

and that death occurred, on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

since March 1920

CONTRIBUTORY (Secondary)

arteriosclerosis

18 Where was disease contracted if not at place of death?

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. K. Gorman, M. D.

19 (Address) 17 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laurel Cemetery

DATE OF BURIAL

July 9 1920

20 UNDERTAKER

Jno. McHugh

ADDRESS

1234 E. Bay St.

Burial Permit Clerk,

D.44627 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 No Wolfe

ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE, NO. 213 No Wolfe

(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 3 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE White	5 Single, Married, Widowed, or Divorced (write the word) Single
-----------------	--------------------------	--

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
67		3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

PARENTS

14 Informant
(Address)

JUL 8 - 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8th 1920

17

I HEREBY CERTIFY, That I attended deceased from June 28th 1920, to July 8th 1920.that I last saw her alive on July 7th 1920.

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 10 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. B. Cook M. D.

1920 (Address) 1920 Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Lawn Cemetery

July 9 1920

20 UNDERTAKER

ADDRESS

Joseph B Cook

1003 N. Baltimore Street

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery Child's Hosp - ST. 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Louise Simonson(Residence in Baltimore: No. Glenn Rock A.A. Co St.; 6 yrs., 24 mos., 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec - 11 - 1919, 1919
(Month) (Day) (Year)

7-AGE, 6 yrs., 24 mos., 24 ds. If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, Isaiah Simonson

11-BIRTHPLACE OF FATHER (State or Country), Westminster Md.

12-MAIDEN NAME OF MOTHER Grace Shipley

13-BIRTHPLACE OF MOTHER (State or Country), Westminster Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. C. Cooks Nursery Child's Hosp.

(Address) Glenn Rock A.A. Co. Franklin St.

15- Robert P. Harrison,

Filed 8-19-20 1920 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH, July 7, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to July 7, 1920, that I saw her alive on July 7, 1920, and that death occurred, on the date stated above, at 10:45 P.m.

The CAUSE OF DEATH* was as follows:

Acute Bleo-Calitis
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....Acidosis
(Secondary)

(Signed) D. J. Feinglass M. D.
7/8/20 (Address) 2007 E Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the 6 yrs., 24 mos., 24 ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Glenn Rock A.A. Co. Md.

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem DATE OF BURIAL, July 9, 1920

20-UNDERTAKER Joseph B. Cook ADDRESS 1033 N. 3rd St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 So. Bond

ST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME FRANK BOCHNAK,

(a) RESIDENCE. NO. 620 So. Bond

ST., 3- WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 COLOR OR RACE white. 5 Single, Married, Widowed, or Divorced (write the word) Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

* * * * *

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 3 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.,

10 NAME OF FATHER Jacob Bochnak,

11 BIRTHPLACE OF FATHER (city or town) Austin, Poland (State or country)

12 MAIDEN NAME OF MOTHER Carolina Rok,

13 BIRTHPLACE OF MOTHER (city or town) Austria, Poland, (State or country)

14 Informant Caroline Bochnak, (Mother)

(Address) # 620 So. Bond Street

15 Filed 8-19-20 Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 th- 19 20

17 I HEREBY CERTIFY, That I attended deceased from July 6, 19 20, to July 8, 19 20, that I last saw him alive on July 8, 19 20,

and that death occurred, on the date stated above, at 1:30 P.-m.

The CAUSE OF DEATH* was as follows:

gouty arthritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Hentz, M. D.

16 V. H. Hentz

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus.

July 9 1920

20 UNDERTAKER

M. F. Sadowski.

ADDRESS

408 S. Ann

Minero
D. 44630 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 44630

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *807 Burgundy* ST.: *21* WARD)

2-FULL NAME

Frank Minero

(a) RESIDENCE, NO.

807 Burgundy ST., *21* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male white Single

4 COLOR OF RACE

5 Single, Married, Widowed, or Divorced write the word

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 30-1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

or min.

9 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Jos Minero

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Genevieve Russe

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

Aug Minero
807 Burgundy St

15

Filed

19

Robert P. Harrison,

Registrar

Jul 8-1920
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 8 1920

17

I HEREBY CERTIFY, that I attended deceased from

July 3, 1920 to July 8, 1920

that I last saw deceased on *July 8, 1920*

and that death occurred, on the date stated above, at *12* m.

The CAUSE OF DEATH was as follows:

Illness Colitis

(duration) yrs. mos. *5* da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

, 19 (Address)

J. G. Schwensberg
1150 W. Lewis St

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Calverton *19 1920*

20 UNDERTAKER

ADDRESS

20 Lakewood 318 Right

CAUSE OF DEATH is very important. See instructions on back of certificates.

1044631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 1044631

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 Ashland Ave. ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Anne Sullivan

(a) RESIDENCE. NO.

821 Ashland Ave

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE color 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Sullivan

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

39

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Lived in Balt- 25 years

10 NAME OF FATHER

Walter Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Lived in Va

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

PARENTS

14 Informant (Address)

John Bell 821 Ashland Ave

15

JUL 9 - 1920

ROBERT E. KRAUTER

Registrar

Burial Permit 1044631

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 12, 1920, to July 6, 1920,

that I last saw him alive on July 6, 1920,

and that death occurred, on the date stated above, at 8:00 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted

Not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Examination of Sputum

(Signed)

Walter H. White M. D.

7/7, 1920

(Address)

1107 Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laural Cemetery

July 9 1920

20 UNDERTAKER

ADDRESS

Mrs R A Elliott

Ashland Ave

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

1044632

HEALTH DEPARTMENT—CITY OF BALTIMORE

1144632

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Biddle & Sellman Sanatorium

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2724 N. Charles

ST.: 7

WARD)

2-FULL NAME

Anna Apple

(a) RESIDENCE. NO.

1825 E. Madison

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

15 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

20

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Jacob Apple

6 DATE OF BIRTH (month, day, and year)

Unknown 1897

7 AGE

43

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Albany, France

10 NAME OF FATHER

Samuel H. H. H. H.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Albany

12 MAIDEN NAME OF MOTHER

H. H. H. H.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Albany

14

Informant (Address)

J. H. H. H.

15

Filed

JUL 9 - 1920

ROBERT B. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 8 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 24, 1920, to July 8, 1920,

that I last saw him alive on July 8, 1920,

and that death occurred, on the date stated above, at 12:50 p. m.

The CAUSE OF DEATH* was as follows:

septic infection secondary to miscarriage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

1825 E. Madison St.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. B. Sellman, M. D.

, 19 (Address) 5 E. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Cemetery

July 9 1920

20 UNDERTAKER

Jack Lewis

ADDRESS

1411 E. Pratt

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates.

1044633 HEALTH DEPARTMENT—CITY OF BALTIMORE

1044633

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 525 N. Preston St. 17

WARD)

2-FULL NAME

Eliza Mason

(Residence in Baltimore: No. 525 N. Preston St.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

40 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Caucasian

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH

November, 1840 (Month) (Day) (Year)

7-AGE

80 yrs., mos., ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired Domestic 670

9-BIRTHPLACE, (State or Country),

Virginia

10-NAME OF FATHER,

George Butler

11-BIRTHPLACE OF FATHER (State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Leah Rodgers

13-BIRTHPLACE OF MOTHER (State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lucy Butler

(Address)

525 N. Preston St.

15.

Filed JUL 9 - 1920

ROBERT A. KRAUTER

Burial Permit Registered

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 7, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease (Duration) 2 yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., ds.

(Signed) J. E. Hennessey M. D. (Coroner.)

July 8, 1920 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

Mt. Auburn

20-UNDERTAKER

Jno. H. Todman

DATE OF BURIAL

July 8, 1920

ADDRESS

142 W. 11th St.

CAUSE OF DEATH in plain terms, so that it may be properly claimed. See instructions on back of certificate.

Lara Gordy.

HEALTH DEPARTMENT—CITY OF BALTIMORE

10 44634

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 Riggs)

2-FULL NAME

(a) RESIDENCE. NO. 1312 Riggs

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds.

ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Gordy.

6 DATE OF BIRTH (month, day, and year)

Nov 7, 1878

7 AGE

41

Months

8

Days

0

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Wife or Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

Washing & Ironing Etc.

(c) Name of employer

Home.

9 BIRTHPLACE (city or town) (State or country)

Cape St. Co. Md.

10 NAME OF FATHER

Robert Gordy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Calver Co. Md.

12 MAIDEN NAME OF MOTHER

Kaziah Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Calver Co. Md.

14 Informant (Address)

John Gordy 1312 Riggs Ave

15

File JUL 9 - 1920

ROBERT E. KAUTER

Registrar

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1920

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1920, to July 6, 1920, that I last saw her alive on July 6, 1920, and that death occurred, on the date stated above, at 5:55 P.M.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Menopause

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

1312 Riggs Ave

Did an operation precede death? None Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Refused Operation Jan 1920

(Signed)

William J. Wright, M.D.

Address

1209 President

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel Cemetery

July 9 1920

20 UNDERTAKER

Sam H. Chase

ADDRESS

1400 Mosher

1844635- HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *St. Agnes Hospital* ST. *25* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *Savage Md.* ST. *Savage Md.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

JUL 9 - 1920

Savage Md.

REGISTRY & RECORDS
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

June 2, 1920, to July 8, 1920

that I last saw her alive on July 8, 1920,

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus
with Metastasis to Brain

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? yes Date of May 1919

Was there an autopsy? no

What test confirmed diagnosis? Microscopic section

(Signed) E. H. Adams M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Savage Md.

July 9 1920

20 UNDERTAKER

ADDRESS

E. B. Harle

115 E West St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *404 S. Highland Ave* ST.; *26* WARD)

2-FULL NAME

(a) RESIDENCE. No. *404 S. Highland Ave.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Single</i>
----------------------	---------------------------------	--

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *June 27-1903*

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<i>17</i>	<i>0</i>	<i>11</i>	

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*at school.*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) *Baltimore Co.
Md.*10 NAME OF FATHER *Fredrick Hohenstein*11 BIRTHPLACE OF FATHER (city or town)
(State or country) *Alexandria
Virginia*12 MAIDEN NAME OF MOTHER *May Erbacher*13 BIRTHPLACE OF MOTHER (city or town)
(State or country) *Germany*14 Informant *Fredrick Hohenstein*
(Address) *404 S. Highland Ave.*15 *JUL 9-1920* ROBERT E. ERBACHER
Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 8 1920*

17

I HEREBY CERTIFY, That I attended deceased from
June 27, 1920, to July 8, 1920
that I last saw him alive on *June 25th, 1920*and that death occurred, on the date stated above, at *1.40* m.

The CAUSE OF DEATH* was as follows:

1. When Tuberculosis(duration) yrs. *6* mos. ds.CONTRIBUTORY *Varicella*
(Secondary)(duration) yrs. *1* mos. ds.

18 Where was disease contracted

If not at place of death? *at school*

Did an operation precede death?

Date of

Was there an autopsy? *No*What test confirmed diagnosis? *Yes*(Signed) *Dr. J. E. Jones*

M. D.

, 19 (Address) *1507 E. Bay View**In case of Disease Preceding Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Sacred Heart Ch.**July 10 1920*

20 UNDERTAKER

ADDRESS

*Lilly and Ziller**403 N. Wolfe*

CAUSE OF DEATH in plain terms, so that the layman can understand. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1703 N. Wolfe St.

ST.:

WARD) 8

2-FULL NAME

William Sherman

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

1703 N. Wolfe St.

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 8-1920

7 AGE

Years

Months

Days

If LESS than 1 day, 2 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

William M. Sherman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Mary C. Finkbeiner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

William M. Sherman 1703 N. Wolfe St.

15

Filed

JUL 9 1920

ROBERT E. KEAULUE

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 8 1920

17

I HEREBY CERTIFY, That I attended deceased from July 5, 1920, to July 5, 1920, that I last saw him alive on July 5, 1920,

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth 6-7 months

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. Rupture of bladder membrane 2 hours (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George A. Hartman M. D.

(Address) 2211 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Sacred Heart Cem.

DATE OF BURIAL

July 9 1920

20 UNDERTAKER

Lilly and Ziehl

ADDRESS

403 N. Wolfe St.

CAUSE OF DEATH is very important. See instructions on back of certificates.

1044638 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044638 CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5311 Hamlin Ave. WARD)2-FULL NAME Barbara Gerhold(a) RESIDENCE. NO. 5311 Hamlin Ave. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 65 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of Geo. H. Gerhold6 DATE OF BIRTH (month, day, and year) Jan 31/31

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant (Address) Chas. H. Jauber
5311 Hamlin Ave

15

File

JUL 9-1920ROBERT E. ERAUTER
Registrar
Baltimore City

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 1st, 1920, to July 7th, 1920.that I last saw her alive on July 6th, 1920.and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy?

What test confirmed diagnosis? Physician Exam

(Signed)

R. C. Smith

M. D.

(Address) 4509 Reisterstown Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Balt Cem.July 9 1920

20 UNDERTAKER

Philip A. KuringADDRESS 2016Chesapeake

1044639

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044639

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 3 Ashland Ave St. 10 WARD)

REGISTERED No. C

2-FULL NAME Nicola Tumminello

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 100 3 Ashland Ave St.; 25 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE,

married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Dec51859

(Month)

(Day)

(Year)

7-AGE,

6072

yrs.

mos.

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Brass worker9-BIRTHPLACE,
(State or Country),Italy

10-NAME OF FATHER,

Salvador Tumminello11-BIRTHPLACE OF FATHER
(State or Country),Italy

12-MAIDEN NAME OF MOTHER

Grace Marcella13-BIRTHPLACE OF MOTHER
(State or Country),Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. M. Brumby(Address) 3103 W. North Ave

15-

JUL 9-1920

Filed

191

ROBERT E. KAUTER

Serial Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July71920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 27, 1920, to July 7, 1920,that I saw him alive on July 6, 1920,and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Duration) 7 yrs. mos. ds.CONTRIBUTORY
(Secondary) (Duration) yrs. mos. ds.(Signed) Engene L. Persano M. D.July 8, 1920 (Address) 2319 E. Balt. Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Cathedral CemeteryJuly 10, 1920

20-UNDERTAKER

ADDRESS

W. G. TuckerN. Pa

important. See instructions on back of certificate.

10.44640

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044640

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2102 W. Fayette ST.; 20 WARD)

REGISTERED NO. C

2-FULL NAME

Rita Matilda Herschel

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2102 W. Fayette St. St.; 1 yrs., 8 mos., 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH

Oct

(Month)

15

(Day)

1915

(Year)

7-AGE

1 yrs., 8 mos., 22 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work

(b) General nature of industry, business,

or establishment in which

employed (or employer)

9-BIRTHPLACE,

(State or Country)

Maryland

10-NAME OF FATHER

John E. Herschel

11-BIRTHPLACE OF FATHER

(State or Country)

MD

12-MAIDEN NAME OF MOTHER

Rosa M. Herschel

13-BIRTHPLACE OF MOTHER

(State or Country)

MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John E. Herschel

(Address)

2102 W. Fayette St.

15-

ROBERT E. KLAUTER

JUL 9 1920

BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July

(Month)

8

(Day)

1920

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 24, 1920, to July 7, 1920,that I saw him alive on July 7, 1920,and that death occurred, on the date stated above, at 8:41 m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

important. See instructions on back of certificate.

1044641 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044641

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 405 N Front ST. 5 WARD) 50
2-FULL NAME Mary A Jones
(Residence in Baltimore: No. 405 N Front St. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female
4-COLOR OR RACE White
5-SINGLE, MARRIED, WIDOWER, OR DIVORCED Widowed
6-DATE OF BIRTH June 22, 1857
(Month) (Day) (Year)

7-AGE, 63 yrs. 16 ds.
If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work... At home
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country), Baltimore Md

10-NAME OF FATHER William K Thompson

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Margaret M. Henry

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie M. Weyer

(Address) 644 E Baltimore St

15- JUL 9-1920 ROBERT A. KRAUTER

Filed... 101... BURIAL PERMIT... State Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 8, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an...
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said...
(Inquest, au-

...find that said deceased came to... death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes (containing)

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

(Address) 628 (Bey)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

New Catholic July 10, 1920

20-UNDERTAKER ADDRESS

9126 Rock 50 26 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

1044642 HEALTH DEPARTMENT—CITY OF BALTIMORE

1044642

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

1548 Argyle Ave

ST.

WARD)

REGISTERED NO. C

2-FULL NAME

Baby Washington

(Residence in Baltimore: No.

1548 Argyle Ave

St.: yrs., mos. 1 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

black

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

single

6-DATE OF BIRTH.

July 6, 1920
(Month) (Day) (Year)

7-AGE.

If LESS than 1 day.

1 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

"Seafarer" 000

9-BIRTHPLACE.
(State or Country),

Balto. Md.

PARENTS.

10-NAME OF FATHER,

Leonard V. Washington

11-BIRTHPLACE OF FATHER
(State or Country),

Lawrence Co. Va

12-MAIDEN NAME OF MOTHER

Mary Hawkins

13-BIRTHPLACE OF MOTHER
(State or Country),

Prince Georges, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Robert B. Keuter

(Address)

N. W. Hill

15-

Filed 9-1920

ROBERT B. KEUTER

101

BRIEF POINT REGISTRAR.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 6, 1920
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patient from man only

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. D. Hennessy M. D.
(Coroner.)

July 6, 1920 (Address) 2803 Edgemoor Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Peter's

DATE OF BURIAL,

July 8, 1920

20-UNDERTAKER

Edward Figgold

ADDRESS

1463 Carey St

CAUSE OF DEATH in plain terms, so that it may be properly entered. See instructions on back of certificate.

1044643. HEALTH DEPARTMENT—CITY OF BALTIMORE 1044643

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2620 Florence

ST.; 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2620 Florence

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

M

4-COLOR OR RACE,

Col.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7/6

(Day)

1920
(Year)

7-AGE,

about 3 yrs.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country), 2620 Florence

10-NAME OF FATHER,

Alvin Brooks

11-BIRTHPLACE OF FATHER

(State or Country), Ind.

12-MAIDEN NAME OF MOTHER

Alvin Brooks

13-BIRTHPLACE OF MOTHER

(State or Country), Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Victor Buchanan

(Address) 2620 Florence St.

15-

Filed

Jul 9-1920

ROBERT H. KRAUTER

Baptist Church Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

1920, to

1920

that I saw h alive on 191

and that death occurred, on the date stated above, at 12 A m.

The CAUSE OF DEATH* was as follows:

7 mor. Choles

(Duration)....yrs....mos....ds.

CONTRIBUTORY

(Secondary)

(Duration)....yrs....mos....ds.

(Signed) B. P. Smith M. D.

7/7, 1920 (Address) 2620 Florence St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Peters

DATE OF BURIAL,

July 8, 1920

20-UNDERTAKER

Edward Figgold 1463 Carey St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2620 Florence W ST.: 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Brooks(Residence in Baltimore: No. 2620 Florence St.: _____ yrs., _____ mos., _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, 7/6, 1920

(Month)

(Day)

(Year)

7-AGE, 2 yrs., _____ mos., _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.10-NAME OF FATHER, Victor Buchanan11-BIRTHPLACE OF FATHER (State or Country), Md.12-MAIDEN NAME OF MOTHER Oliver Brooks13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Victor Buchanan(Address).....2620 Florence W

15-

JUL 9-1920

ROBERT E. KAUTER

Filed.....

191.....

BALTIMORE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7/8, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from 7/6 1920, to 7/8 1920,that I saw him alive on 7/8 1920,and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth(2 mos. child)

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed).....Wm. R. Hutter M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St PetersDATE OF BURIAL, July 9th, 192020-UNDERTAKER, Edw. RuggoldADDRESS, 1463 Carey St

important. See instructions on back of certificate.

1044645 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044645

50
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

Johns Hopkins Hospital

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Bernard Conrad

(a) RESIDENCE. NO.

609 N. Belwood Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Color White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

X

6 DATE OF BIRTH (month, day, and year)

2.

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Shaw's Paint

9 BIRTHPLACE (city or town)
(State or country)

Maryland

10 NAME OF FATHER

Thomas Payne

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Emma Schuchman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Maryland

14

Informant
(Address)

2444 Greenleaf

15

JUL 9 - 1920

ROBERT H. KLESTER

Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 8 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 6, 1920, to July 8, 1920,

that I last saw him alive on July 8, 1920,

and that death occurred, on the date stated above, at 12:55 P.M.

The CAUSE OF DEATH was as follows:

Diabetes mellitus

(duration) yrs. 8 mos. ds.

CONTRIBUTORY
(Secondary)

Diabetic Coma

(duration) yrs. 3 mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

Chemical Blood

(Signed)

Schuchman, M. D.

(Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Lawn Cemetery

July 12, 1920

20 UNDERTAKER

Mrs. C. Miller

ADDRESS

2334 Jefferson St.

CAUSE OF DEATH
TION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Baker(a) RESIDENCE. No. 710 Dover St.

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male Colored Unknown5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) Unknown7 AGE about Years 35 Months Days If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)14 Informant Hospital Records.
(Address) New City Hospital.15 Filed 9-1920 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 192017 I HEREBY CERTIFY, That I attended deceased from
July 6, 1920, to July 7, 1920,
that I last saw him alive on July 7, 1920,
and that death occurred, on the date stated above, at 11:20 A.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis with
cerebral thrombosis.CONTRIBUTORY Chronic diffuse
(Secondary) pneumonitis
(duration) ? yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? No special test
(Signed) W. H. H. H. H. H., M. D.(Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND.JUL 9 1920

20 UNDERTAKER

ADDRESS

D.44647 HEALTH DEPARTMENT—CITY OF BALTIMORE D.44647

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Barrett(a) RESIDENCE. NO. Bay View Asylum
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male White Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18547 AGE Years Months Days If LESS than 1 day, hrs. or min.
66

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town)
(State or country)Ireland10 NAME OF FATHER John Barrett11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland12 MAIDEN NAME OF MOTHER Mary Lacy13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland14 Informant Hospital Records
(Address) M.T.H.15 Filed Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 192017 I HEREBY CERTIFY, That I attended deceased from
May 31, 1920, to July 7, 1920
that I last saw him alive on July 6, 1920
and that death occurred, on the date stated above, at 8.15 a. m.
The CAUSE OF DEATH* was as follows:Pulmonary tuberculosis(duration) yrs. 7 mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum(Signed) George R. Wilkinson M. D.7-7-20 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

UNIVERSITY OF MARYLAND

20 UNDERTAKER

Jul 9 1920

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

JUL 9 - 1920

17348

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 McHenry ST.; 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annice Arena Davis(Residence in Baltimore: No. 1909 McHenry St.; 38 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. married (Write the word.)6-DATE OF BIRTH, 3 30, 1866
(Month) (Day) (Year)7-AGE, 54 yrs., 3 mos., 9 ds. If LESS than 1 day, ... hrs., or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer)... 0399-BIRTHPLACE, (State or Country), Winchester, Md10-NAME OF FATHER, Coshua Brown11-BIRTHPLACE OF FATHER (State or Country), Maryland12-MAIDEN NAME OF MOTHER unknown13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THIS ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Davis(Address) 1909 McHenry St

15-

Filed 1920 Robert P. Har Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH, 7 8, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from fall 1910, to 7-8 1920, that I saw her alive on July 7 1920, and that death occurred, on the date stated above, at 11:20 a.m.

The CAUSE OF DEATH* was as follows:

Osteosis deformans
(Duration) 12 yrs., 5 mos., 5 ds.CONTRIBUTORY. Albuminuria
(Secondary) hematogenic (Duration) 6 yrs., 6 mos., 5 ds.
(Signed) R. B. Wilson M. D.
7-9, 1920 (Address) 1124 W. LAFAYETTE AVE.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Landon Park Cemetery July 17, 1920

20-UNDERTAKER

ADDRESS

Geo. A. Gerbig 2001 W. Baltimore St

D. 44649 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 44649

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital*) *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *James A Knight*

(a) RESIDENCE. NO. *814 N Broadway* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *3* yrs. *1* mos. *17* ds. How long in U. S., if of foreign birth *Life* yrs. *1* mos. *17* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *married*

5a If married, widowed, or divorced HUSBAND of *Laura J Knight* (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 20 1843*

7 AGE Years *76* Months *10* Days *22* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *teacher*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *New Jersey* (State or country)

10 NAME OF FATHER *James Knight*

11 BIRTHPLACE OF FATHER (city or town) *England* (State or country)

12 MAIDEN NAME OF MOTHER *Mary Ann Bettridge*

13 BIRTHPLACE OF MOTHER (city or town) *England* (State or country)

14 Informant *J H H Records* (Address)

15 Filed *19* *Robert P. Harrison* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 8 1920*

17 I HEREBY CERTIFY, That I attended deceased from *June 23*, 19*20*, to *July 8*, 19*20*, that I last saw him alive on *July 8*, 19*20*, and that death occurred, on the date stated above, at *9:30 P. m.*

The CAUSE OF DEATH* was as follows:

Pelvic abscess, 2° Chronic nephritis

CONTRIBUTORY (Secondary) *Hypertrophy prostate* (duration) *25* yrs. *13* mos. *13* ds. (duration) *0* yrs. *0* mos. *0* ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *Yes*, Date of *April 5th*

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Yes*

(Signed) *Harvard & Cecil* M. D.

19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore *July 12 1920*

20 UNDERTAKER ADDRESS *1739*
Groble & Groble *Eager*

TION is very important. See instructions on back of certificates.

JUL 9 - 1920

N. B.-Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION, state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

10.44650 HEALTH DEPARTMENT--CITY OF BALTIMORE 10.44650

CERTIFICATE OF DEATH

1-PLACE OF DEATH

135 REGISTERED No. C

CITY OF BALTIMORE (No. 1907 Homewood Ave. 9 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Cole Hubbard

(Residence in Baltimore: No. 1907 Homewood Ave. 2 St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word)

6-DATE OF BIRTH Jan 28, 1893 (Month) (Day) (Year)

7-AGE 27 yrs. 5 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Homemaker (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Balto Md

10-NAME OF FATHER Charles E. Cole

11-BIRTHPLACE OF FATHER (State or country) Baltimore - Md

12-MAIDEN NAME OF MOTHER Lottie Shreves

13-BIRTHPLACE OF MOTHER (State or country) Baltimore - Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Raymond Hubbard

(Address) 1907 Homewood Ave

15 JUL 9-1920 Robert P. Harrison,

Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 9, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 191 to July 9th 1920, that I saw her alive on July 9th 1920, and that death occurred, on the date stated above, at 4:45 a.m. The CAUSE OF DEATH* was as follows:

Stroke (Hemorrhage - Cerebral)

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) J. S. H. Carter M. D.

7-9, 1920 (Address) 508 E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Greenmount July 13, 1920

20-UNDERTAKER ADDRESS

William Cook 562 E North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 1082

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 214. N. Durham ST. 6 WARD) 6

2-FULL NAME Mrs Margaret Dorsey

(a) RESIDENCE. NO. 214. N. Durham ST. 6 WARD.

(Usual place of abode)
Length of residence in city or town where death occurred 47 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work Domestic 070(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer Mrs Sarah Watson

9 BIRTHPLACE (city or town)
(State or country) Md.

10 NAME OF FATHER John Dorsey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balt. Md.

12 MAIDEN NAME OF MOTHER Rebecca Chapman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) St. Mary's Md.14 Informant
(Address) Joseph P. Dorsey

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1920

17 I HEREBY CERTIFY, That I attended deceased from
June 10, 1920, to July 9, 1920,
that I last saw her alive on July 7, 1920,
and that death occurred, on the date stated above, at 1:15 p.m.The CAUSE OF DEATH* was as follows:
PneumoniaCONTRIBUTORY
(Secondary)18 Where was disease contracted
if not at place of death? Balt. Md.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John M. Deather

, 19 (Address) 1402-72nd St

*State the Disease Causing Death, or in deaths from Violent Cause,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

Hilbury Cemetery July 12 1920
Milton Davis 413 N Eden StCAUSE OF DEATH in plain terms, see instructions on back of certificates.
TION is very important. See instructions on back of certificates.

10. 44652 HEALTH DEPARTMENT—CITY OF BALTIMORE

10. 44652

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST.; *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *John E. Zeller*(a) RESIDENCE. NO. *603 N. Galloway Ave* ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Child*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Child*6 DATE OF BIRTH (month, day, and year) *June 28-1920*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *11*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.* (State or country)10 NAME OF FATHER *John Zeller*11 BIRTHPLACE OF FATHER (city or town) *Md.* (State or country)12 MAIDEN NAME OF MOTHER *Rosalind Burger*13 BIRTHPLACE OF MOTHER (city or town) *Md.* (State or country)14 Informant *Hospital Record* (Address) *H. H.*15 *JUL 9-1920* Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 9 1920*

17

I HEREBY CERTIFY, That I attended deceased from *July 6*, 1920, to *July 9*, 1920, that I last saw him alive on *July 9th*, 1920, and that death occurred, on the date stated above, at *10:15* a.m.

The CAUSE OF DEATH* was as follows:

Injury by forceps at birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Septicemia*(duration) yrs. mos. *7* ds.

18 Where was disease contracted

if not at place of death? *Home?*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Harold L. Higgins*, M. D.719, 1920 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Lorane Cemetery**July 10 1920*

20 UNDERTAKER

ADDRESS

Geo M. Pinson 811 N. Wolfe

CAUSE OF DEATH is very important. See instructions on back of certificates.

D. 44653

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44653

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 Cereal

ST.: 75 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Eva M. Gembicka

(a) RESIDENCE. NO.

14 Cereal St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

Sept. 9-1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

10

0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

" "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Stanislaw Gembicka

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Antonina Gembicka

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14 Informant (Address)

St. Gembicka, Curtis Bay

15

Filed

Robert F. Harrison, Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 9 1920

17

I HEREBY CERTIFY, That I attended deceased from July 8, 1920, to July 9, 1920, that I last saw him alive on July 8, 1920, and that death occurred, on the date stated above, at 9.30 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

duration) unknown

CONTRIBUTORY (Secondary)

Unknown

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. B. Horton, M.D. Address) 1 Cedar St. Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross

7/10 1920

20 UNDERTAKER

Wm. Galt (Galt) 16 East

JUL 9-1920

Burial Permit Clerk.

6
N. B.—While preparing this certificate, information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D. 44654 HEALTH DEPARTMENT—CITY OF BALTIMORE 10,44654

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp St.* ST.; *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Henry Mattoy

(a) RESIDENCE. NO.

Black Creek N.C.

WARD

Black Creek N.C.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Single</i>
----------------------	---------------------------------	---

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Single*6 DATE OF BIRTH (month, day, and year) *Dec 29-1869*7 AGE *50* Years *6* Months *10* DaysIf LESS than
1 day, ... hrs.
or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *North Carolina*
(State or country)

10 NAME OF FATHER

*J. R. Mattoy*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*N. C.*

12 MAIDEN NAME OF MOTHER

*Ara Scott*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*N. C.*

14

Informant
(Address)*Hospital Record
J. R. Mattoy*

15

Filed

JUL 9-1920

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 9* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

June 25, 19*20*, to *July 9*, 19*20*,that I last saw him alive on *July 9*, 19*20*,and that death occurred, on the date stated above, at *2:25 p.m.*

The CAUSE OF DEATH* was as follows:

Pellagra(duration) ... yrs. *11* mos. ... ds.CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted
if not at place of death?*N. Carolina*Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

F. Schumacher

M. D.

, 19*19* (Address)*Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Black Creek N.C.**July 10* 19*20*

20 UNDERTAKER

William G. Schaffer

ADDRESS

18 Mount

CASE OF DEATH. TION is very important. See instructions on back of certificates.

D. 44655

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44655

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

— mos.

— ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

JUL 9 1920

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1920

17

I HEREBY CERTIFY, That I attended deceased from

July 12th, 1919, to July 7th, 1920.that I last saw him alive on July 7th, 1920.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Hæmorrhage from Lung.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hæmorrhage

(Signed) Dr. C. Gasker, M. D.

, 19 (Address) 1114 Harp Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D. 44656

122

REGISTERED No. C

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

...St.; 1 yrs., mos. ds.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 7th. 1920., 191.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the
remains described above, held an Autopsy & Inquiry
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said. Inqury...
(Inquest, au-
& Autopsy....and that said deceased came to his death
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Pyelonephritis.

..... (Duration)..... yrs..... mos..... ds.
CONTRIBUTORY. Bilateral Pleurisy &.....
 (Secondary)

(Secondary) Septic Pneumonia.
..... (Duration) yrs. mo. ds.
(Signed) Otto McReinhart M. D.

July 9, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place _____ In the _____
of death.....yrs.....mos.....ds, State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.

Montaview Cemetery ^{Howards} Ind., July ... 192...

20-UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. **Important.** See instructions on back of certificate.

Filed JUL 9 1920

Robert F. Harrison,

Burial Permit Class. 14-00000

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. 709 Dolphin St. 17 WARD)
2-FULL NAME Austin F. Bayle
(Residence in Baltimore: No. 709 Dolphin St. 64 St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male	4-COLOR OR RACE. white	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. widow
6-DATE OF BIRTH. Unknown, 1856		
7-AGE. 64 yrs. mos. ds.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). retired wholesaler, whiskey clerk		
9-BIRTHPLACE. (State or Country). Baltimore, Md.		
PARENTS.	10-NAME OF FATHER. Edward Bayle	11-BIRTHPLACE OF FATHER. (State or Country). Ireland
	12-MAIDEN NAME OF MOTHER. Ellen Smith	13-BIRTHPLACE OF MOTHER. (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Miss Ann E. H. Bayle
(Address) 2632 N. Charles St.

15- Robert P. Harrison,
Filed 10 1920, 101
Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH.
July 8, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH was as follows:

Chronic Industrial Nephritis

(Duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Arterio Sclerosis

(Signed) J. D. Hennessey, M. D.
(Coroner.)
July 9, 1920 (Address) 2802 Raduondy St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.
Cathedral
DATE OF BURIAL.
July 10, 1920

20-UNDERTAKER
H. W. Mead
ADDRESS
705 Calver

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificate.

JUL 10 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. _____)

2-FULL NAME

(Residence in Baltimore: No. _____)

St.; _____ WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; _____ yrs., 10 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

Aug 23, 1919
(Month) (Day) (Year)

7-AGE.

10 yrs. 10 mos. 16 ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Chief

9-BIRTHPLACE.
(State or Country).

Hartford Co. Md.

10-NAME OF FATHER.

Wm W. Little

11-BIRTHPLACE OF FATHER
(State or Country).

Delaware

12-MAIDEN NAME OF MOTHER

Leila Crawford

13-BIRTHPLACE OF MOTHER
(State or Country).

Hartford Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert R. Harrison,

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 9, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
June 25, 1920, to July 9, 1920,
that I saw him alive on July 8, 1920,
and that death occurred, on the date stated above, at 2:35 p.m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatism

(Duration)....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration)....yrs.....mos.....ds.

(Signed)..... M. D.

7/9/1920 (Address) 2002 E. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs. 4 mos. 14 ds. In the State....yrs. 10 mos. 16 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Catholic M. & Church Cemetery
Baltimore, Maryland

20-UNDERTAKER

George Smith

DATE OF BURIAL.

July 11, 1920

ADDRESS

2002 E. Pratt St.

important. See instructions on back of certificate.

D. 44659

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44659
50

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 Krumm ST. Hamilton WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 10 Krumm ST. Hamilton WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofJames B. Carroll6 DATE OF BIRTH (month, day, and year) May 19 - 18557 AGE Years Months Days If LESS than 1 day, hrs. or min.
65 1 28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) MD10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown14 Informant William B. Bailey (Address) 101 Krumm15 Filed 10 1920 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7 - 8 19 2017 I HEREBY CERTIFY, That I attended deceased from June 17, 1920, to July 8, 1920, that I last saw her alive on July 8, 1920 and that death occurred, on the date stated above, at 11-30 P. m.

The CAUSE OF DEATH* was as follows:

Dilated Heart

12 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

12 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Autopsy(Signed) W. B. Bailey, M. D.19 (Address) 2105 1/2 Clark St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Restgarden Md July 10 19 20

UNDERTAKER ADDRESS

W. B. Bailey

Burial Permit Clerk.]

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2135 Woodlea ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mileva Lincher(a) RESIDENCE. NO. 213 P. Woodlea ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 4 mos. 4 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M4 COLOR OR RACE N5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 4 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 4 4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balti. Md
(State or country)10 NAME OF FATHER Toca Swick11 BIRTHPLACE OF FATHER (city or town) Dick
(State or country)12 MAIDEN NAME OF MOTHER Mary Pachor13 BIRTHPLACE OF MOTHER (city or town) Dick
(State or country)

14

Informant Toca Swick
(Address) 213 P. Woodlea

15

Filed 10 1920Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-9 1920

17

HEREBY CERTIFY, That I attended deceased from July 8, 1920, to July 9, 1920, that I last saw him alive on July 9, 1920; and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac FailureCONTRIBUTORY (Secondary) Gastro Enterit (duration) yrs. 2 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? X(Signed) W. M. Harris M. D.7/10, 1920 (Address) 1502 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Goudon ParkJuly 10 1920

20 UNDERTAKER

ADDRESS

John J. Fields 1200 W. Lombard

CAUSE OF DEATH. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2226 Christine* ST. *20* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2226 Christine St* St. *20* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

July 15, 19*78*
(Month) (Day) (Year)

7-AGE,

*41*yrs. *11* mos. ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Watchman*9-BIRTHPLACE,
(State or Country),*Philadelphia*

10-NAME OF FATHER,

*Antonio J. Moebius*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*Laura W. Koes*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

Annie E. Moebius

(Address)...

2226 Christine St

15-

Filed.....

*Robert P. Harrison,**191*

Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 8, 19*80*
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

February 10 19*20*, to *July 8* 19*20*,that I saw him alive on *July 8* 19*20*,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

*Pulmonary Tuberculosis**Unattended*CONTRIBUTORY
(Secondary)*Indurated*(Signed) *Robert P. Harrison* M. D.*July 9*, 19*20* (Address) *215 N. Hollen Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. mos. ds. In the State.....yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Call Lawn Cemetery *July 12*, 19*20*

20-UNDERTAKER

ADDRESS

Robert J. Turner *1442 N. Broadway*

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2770 Alameda ST.; 9 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta Ruff(Residence in Baltimore: No. 2770 Alameda St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female4-COLOR OR RACE, White5-SINGLE, Widowed
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, Unknown, 1839

(Month)

(Day)

(Year)

7-AGE, 82

yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany10-NAME OF FATHER, Leo Ruff11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER, not known13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Ruff(Address) 2770 Alameda

15-

Robert P. Harrison

FILED

JUL 10 1920

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 9, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1920, to July 9 1920, that I saw her alive on July 9 1920, and that death occurred, on the date stated above, at 5 p. m. The CAUSE OF DEATH* was as follows:Endocarditis, Old age
(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Frank Ruff M. D.
July 10, 1920 (Address) 1228 N. Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery DATE OF BURIAL, July 12, 192020-UNDERTAKER, Robt J TurnerADDRESS 1442 Broadway

D. 44663

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044663

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Udis(a) RESIDENCE. No. 606¹ Linwood Ave ST. 1 WARD. 1

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of Mary
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Unknown 18757 AGE 45 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lithuania
(State or country)10 NAME OF FATHER P11 BIRTHPLACE OF FATHER (city or town) Lithuania
(State or country)12 MAIDEN NAME OF MOTHER P13 BIRTHPLACE OF MOTHER (city or town) Lithuania
(State or country)14 Informant Jon Udis
(Address) 606¹ Linwood Ave15 Filed 10 1920 Robert P. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 19 2017 I HEREBY CERTIFY, That I attended deceased from July 9 19 20, to July 9 19 20,
that I last saw him im dead alive on July 9 19 20.and that death occurred, on the date stated above, at 4:35 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema(duration) yrs. mos. 1 ds.CONTRIBUTORY Acute Nephritis
(Secondary) (duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical signs
(Signed) I. B. Bronuska, M. D.-9, 19 20 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cem7-12th 19 20

20 UNDERTAKER

ADDRESS 17, S.Robert Brooks & SonCalhoun st

CAUSE OF DEATH IN PARTIALITY OF INSTRUCTIONS ON BACK OF CERTIFICATES. See instructions on back of certificates. TION is very important.

D. 44664

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44664

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 Argyle Avenue ST. 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Baby Overton

Residence in Baltimore: No.

917 Argyle Avenue

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word) Single

6-DATE OF BIRTH.

July61920

7-AGE.

yrs. mos. ds.

If LESS than 1 day, ... hrs. or 15 min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Md.

10-NAME OF FATHER.

John Overton

11-BIRTHPLACE OF FATHER (State or Country).

Md.

12-MAIDEN NAME OF MOTHER

Julia Henry

13-BIRTHPLACE OF MOTHER (State or Country).

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Overton(Address) 917 Argyle Ave

15-

MUL 10 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July61920

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from July 6th 1920 to July 6th 1920, that I saw him alive on July 6th 1920, and that death occurred, on the date stated above, at 917A.

The CAUSE OF DEATH* was as follows:

Placental birth
34 weeks at birth

CONTRIBUTORY (Secondary)

Hamorrhage
(Signed) R. P. Harrison M. D.
July 9, 1920 (Address) 924 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Channing Ave

DATE OF BURIAL,

July 6, 1920

20-UNDERTAKER

ADDRESS

over

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2114 CambrigeST.: I WARD)

2-FULL NAME

MARIA TYMA,

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 2114 CambrigeST., I WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 1 mos. 28

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female,

4 COLOR OR RACE

White,5 Single, Married, Widowed,
or Divorced (write the word)
Single,5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) May 12/20.

7 AGE

Years

Months

Days

1228If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workInfant,(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore,Md.,

10 NAME OF FATHER

Michael Tyma,

11 BIRTHPLACE OF FATHER (city or town)

Baltimore,

(State or country)

Md.,12 MAIDEN NAME OF MOTHER Anna Urcik,

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore,

(State or country)

Md.,

14

Informant Michael Tyma, (Father)(Address) 2114 Cambrige Street

15

JUL 10 1920Robert P. Harrison,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10th 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 9, 1920, to July 10, 1920,
that I last saw her alive on July 9, 1920.and that death occurred, on the date stated above, at 1255 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria (acute)(duration) yrs. mos. 2 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Rehberger M. D., 19 (Address) 1709 Alix Street*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Stanislaus,

20 UNDERTAKER

W. J. Sadowski,

DATE OF BURIAL

7/10- 1920

ADDRESS

705 S. Ann

CAUSE OF DEATH in plain terms, so that it can be understood by the layman. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 N. Ellington Ave. WARD)2-FULL NAME: Brothera Lutz(a) RESIDENCE, NO. 1206 N. Ellington Ave.
(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

Superior ds.

How long in U. S., if of foreign birth?

20 yrs

8 mos.

6 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

W.5 Single, Married, Widowed,
or Divorced (write the word)Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 3, 1899

7 AGE

Years

20

Months

8

Days

6If LESS than
1 day. hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore, Md.

10 NAME OF FATHER

Henry Lutz11 BIRTHPLACE OF FATHER (city or town)
(State or country)Balt., Md.

12 MAIDEN NAME OF MOTHER

Gertrude13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Balt., Md.

14

Informant
(Address)Sharon, Danz
1206 N. Ellington Ave.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 9, 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 1st 1920, to July 9, 1920that I last saw him alive on July 8, 1920.and that death occurred, on the date stated above, at 10:15 A. M.

The CAUSE OF DEATH* was as follows:

Epilepsy(duration) 20 yrs. 8 mos. 6 ds.CONTRIBUTORY
(Secondary)Scarlet Fever(duration) 8 yrs. 8 mos. 8 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical symptoms(Signed) W. H. Singmaster M. D.7/9, 1920 (Address) 1613 E. North Ave.*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Trinity CemeteryJuly 11, 1920

20 UNDERTAKER

John Herwig & Co.

ADDRESS

2008 Wilkes

JUL 16 1920

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 N. Guilmer St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 426 N. Guilmer St.; 89 yrs., 6 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 1 1915, to July 9 1920,

that I saw him alive on June 1 1920,

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Sensibility

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....John D. Wang.....M. D.

July 10, 1920 (Address) 1425 Eutan Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

JUL 16 1920

Burial Permit No. 101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

934 N. Belmar

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Recheal M. Pugh

(a) RESIDENCE. NO.

934 N. Belmar

ST.

WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred

8

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Charles W. Pugh

6 DATE OF BIRTH (month, day, and year)

July 14-1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

73

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Liberty Grove Md

10 NAME OF FATHER

Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

" "

12 MAIDEN NAME OF MOTHER

" "

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

" "

14

Informant (Address)

Charles W. Pugh

934 N. Belmar St

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 9th 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 8, 1920, to July 9, 1920,

that I last saw her alive on July 9, 1920,

and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration)

yrs. 2

mos.

ds.

CONTRIBUTORY (Secondary)

Hypertensive Congestion of Lungs

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Chas. A. Schaefer

M. D.

19

(Address)

53. J. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western

July 12-1920

20 UNDERTAKER

Wm. Cook

ADDRESS

582 E. Hall Ave

CAUSE OF DEATH IN PLAIN ENGLISH. See instructions on back of certificates. TION is very important.

JUL 16 1920

Burial Permit Clerk.

D. 44669 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 44669

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 Ivy alley

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Annie E. Henderson

(Residence in Baltimore: No. 211 Ivy alley

St.; 45 yrs., — mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

—, 1865
(Month) (Day) (Year)

7-AGE,

50 yrs. — mos. — da.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Sundress

(b) General nature of industry, business, or establishment in which employed (or employer).

Family Sundress

9-BIRTHPLACE,

(State or Country).

Dorchester Co. Md

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER (State or Country),

do

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER (State or Country),

do

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William L. Harrison

(Address) 211 Ivy alley

15-

JUL 10 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 8th 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 23 1920, to July 8 1920, that I saw him alive on July 7th 1920, and that death occurred, on the date stated above, at 9 P. m. The CAUSE OF DEATH* was as follows:

Cardiac Arrest (Duration) ... yrs. ... mos. ... ds.
 CONTRIBUTORY (Secondary) ...
 Hemiplegia (Duration) ... yrs. ... mos. ... ds.
 (Signed) Edward E. Harrison M. D.
 July 9 1920 (Address) 1339 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Bethel

DATE OF BURIAL,

July 10, 1920

20-UNDERTAKER

Daniel Taylor

ADDRESS

916

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *15-38* *Leslie St*)

ST.:

WARD) *15-91*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Jennett Jones*(a) RESIDENCE. No. *15-38* *Leslie*

(Usual place of abode)

ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *3* yrs.

mos.

ds. How long in U. S., if of foreign birth? *Life* yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

♀

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 1917*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Ind*
(State or country)10 NAME OF FATHER *Leah Jones*11 BIRTHPLACE OF FATHER (city or town) *Ind*
(State or country)12 MAIDEN NAME OF MOTHER *May Lawson*13 BIRTHPLACE OF MOTHER (city or town) *Ind*
(State or country)

14

Informant *May Lawson*
(Address)

15

Filed *16* *1920* *Robert P. Harrison,*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *7-8* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

7/6 - , 19*20*, to *7/8* - , 19*20*,that I last saw *her* alive on *7/8* - , 19*20*,and that death occurred, on the date stated above, at *9:15* m.

The CAUSE OF DEATH* was as follows:

Branches - Pneumonia(duration) yrs. mos. *3* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Frank E. Butler*, M. D., 19 (Address) *2139 W 4th St - C*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*mt auburn**July 10* 19*20*

20 UNDERTAKER

ADDRESS

JAMES H. DENNIS

1303 PRESTMAN ST.

TION is very important. See instructions on back of certificates.

D. 44671 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 44671

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE

(No. *St Josephs Hospital* ST. *27* WARD)

2-FULL NAME

Mrs Helia Strandenmayer

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

238 Hamilton Ave ST. *130* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *58* yrs. *3* mos. *14* ds. How long in U. S., if of foreign birth? *10* yrs. *10* mos. *14* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

David J. Strandenmayer

6 DATE OF BIRTH (month, day, and year)

March 25th

7 AGE

58

Years

58

Months

3

Days

14

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Housewife**At Home*

9 BIRTHPLACE (city or town) (State or country)

Hamilton Maryland

10 NAME OF FATHER

Wm H. Read

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Hamilton Maryland

12 MAIDEN NAME OF MOTHER

Julia A. Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Maryland

14

Informant

(Address)

*David J. Strandenmayer**238 Hamilton Ave**Robert P. Harrison,*

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*July 9*19 *20*

17

I HEREBY CERTIFY, That I attended deceased from *June 30*, 19 *20*, to *July 9th*, 19 *20*, that I last saw her alive on *July 9*, 19 *20*.and that death occurred, on the date stated above, at *8* A. M.

The CAUSE OF DEATH* was as follows:

Septicemia, cause unknown(duration) yrs. mos. *10* ds.CONTRIBUTORY *Complicating Meningitis* (Secondary) (duration) yrs. mos. *4* ds.

18 Where was disease contracted

If not at place of death? *unknown*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *clinical signs & symptoms*(Signed) *David Miller* M. D., 19 (Address) *St Josephs Hospital*

*State the Disease Causing Death, & in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Druid Ridge Cemetery

DATE OF BURIAL

July 12 1920

20 UNDERTAKER

Frank L. Lippman

ADDRESS

238 Hamilton Ave

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

JUL 10 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.:

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Chas. V. O'Connor

6 DATE OF BIRTH (month, day, and year)

Aug. 9 - 1897

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

22

11

—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Ind

10 NAME OF FATHER

Albert Repphun

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Jauber

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Germany

14

Informant
(Address)Chas. V. O'Connor Jr.
1209 E. Preston St.

15

Filed

Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 9 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 23, 1920, to July 9, 1920,

that I last saw her alive on July 9, 1920,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Clinical findings

(Signed)

F. C. Martin M. D.

, 19

(Address)

St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Holy Redeemer
Chas. J. Evans & Son 718 N. Mt. Royal

7/12 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST. *22* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Amos Toney*(a) RESIDENCE. NO. *147*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *2*

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD. *Sollers Whf. Cal. Co. Md.*

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *4/12/1912*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Maryland*10 NAME OF FATHER *Robert Toney*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Md.*12 MAIDEN NAME OF MOTHER *Anna H. H. H.*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Hospital Records

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 9 1920*

17

I HEREBY CERTIFY, That I attended deceased from *Sept. 29, 1919*, to *July 9, 1920*, that I last saw him alive on *July 9, 1920*, and that death occurred, on the date stated above, at *6:40 P. m.*

The CAUSE OF DEATH* was as follows:

*Tuberculosis of tip
Tuberculous Peritonitis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *Oct. 27, 1919*Was there an autopsy? *yes*

What test confirmed diagnosis?

(Signed) *William H. H. H.*, M. D.7/9, 1920 Address *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Sollers Whf. Cal. Co. Md. July 10 1920

20 UNDERTAKER

John H. Loderer W. Heils

CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

044674

1044674

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bay View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 12 WARD

2-FULL NAME

John M. Harvey

(a) RESIDENCE. No.

117 W. 21st

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

70

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Do.

12 MAIDEN NAME OF MOTHER

Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Do.

14

Informant (Address)

Bay View Hospital
Baltimore, Md.

15

Filed

19

ROBERT E. LUTHER
Registrar

JUL 11 1920

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 9, 1920

17

I HEREBY CERTIFY, That I attended deceased from

March 4, 1920

July 9, 1920

that I last saw him alive on

July 9, 1920

and that death occurred, on the date stated above, at

4:25 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

CONTRIBUTORY (Secondary)

Arterio Sclerosis

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

N. J. G. Smith M. D.

1/10/1920 (Address)

Bay View Hospital

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn

July 12, 1920

20 UNDERTAKER

ADDRESS

Joseph A. Farrell

2519 Dunbar

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

D44675

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044675

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1925 E. Fairmount St.)

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Leah Brown

(a) RESIDENCE. NO.

1925 E. Fairmount St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

18 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Fem.

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 23/1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md

10 NAME OF FATHER

Jacob Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Sarah Golda Rosenbaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

14

Informant (Address)

Jacob Brown 1925 E. Fairmount Ave

15

Filed

JUL 11 1920

ROBERT E. KAUFER

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 14 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 8 1920, to July 11 1920, that I last saw her alive on July 11 1920.

and that death occurred, on the date stated above, at 330 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary)

None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted If not at place of death?

Hebrew Hospital

Did an operation precede death? no Date of

Was there an autopsy?

no

What test confirmed diagnosis?

physical findings

(Signed)

M. H. Lurie

M. D.

1/11 1920 (Address)

34 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Rosedale Cemetery

July 11 1920

20 UNDERTAKER

May Lunsford

ADDRESS 1127 E

Baltimore

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates.

7M4V. 3814

Spec.—8-24 14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044676

1044676

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1441 Homestead ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Julia A. Smith
(Residence in Baltimore: No. 1441 Homestead St.: 93 yrs. 0 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female. 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widow
(Write the word.)
6-DATE OF BIRTH, June 16th 1827
(Month) (Day) (Year)

7-AGE, 93 yrs. 0 mos. 23 ds. If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House Duties
(b) General nature of industry, business, or establishment in which employed (or employer). at home

9-BIRTHPLACE, (State or Country), Baltimore Co.

10-NAME OF FATHER, George Bishop

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Co.

12-MAIDEN NAME OF MOTHER, Rebecca Fowler

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Irwin Smith
(Address) 1441 Homestead St.

15-JUL 11 1920 191... B.O.R.I.A.L. P.E.R.M.I.L. O.I.A.M. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 9th 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1919, to July 8th 1920, that I saw her alive on July 8th 1919, and that death occurred, on the date stated above, at 5 A.M.
The CAUSE OF DEATH* was as follows:

Paralysis
Thrombophlegma
(Duration)yrs. 7 mos. 5 ds.

CONTRIBUTORY (Secondary) (Duration)yrs. 7 mos. 5 ds.

(Signed) Charles E. Gaudin M. D.
July 9th 1920 (Address) Towson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bowler Cemetery DATE OF BURIAL, July 12th 1920

20-UNDERTAKER, Mrs. John H. Puffer ADDRESS, 801 N. Fayette St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male White Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Corrie M Rehberger

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

JUL 11 1920

ROBERT E. KRAUTER

Registrar

BRIEF EXHIBIT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

May 22, 1920, to May 27, 1920, that I last saw him alive on May 27, 1920, and that death occurred, on the date stated above, at 5:45 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

July 12th 1920

20 UNDERTAKER

George Schilling & Sons 1126 E. Monument St.

CAUSE OF DEATH in plain terms. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044678

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Colored

5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

Jan 29, 1920
(Month) (Day) (Year)

7-AGE.

5 yrs. 10 mos. 10 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

Trade, profession, or particular
kind of work.
(b) General nature of industry, business, or establishment in which
employed (or employer).

None

9-BIRTHPLACE,
(State or Country).Baltimore
Maryland10-NAME OF
FATHER.

Franklin West

11-BIRTHPLACE
OF FATHER
(State or Country).

Pennsylvania

12-MAIDEN NAME
OF MOTHER

Sophia Fillman

13-BIRTHPLACE
OF MOTHER
(State or Country).

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

Sophia West
2707 Garrison Ave

15-

Filed

JUL 11 1920

ROBERT B. KRAUTER

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 9, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 20, 1920, to July 9, 1920,

that I saw her alive on July 9, 1920,
and that death occurred, on the date stated above, at 7:40 P. m.

The CAUSE OF DEATH* was as follows:

Ileus Colitis

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. S. Mable M. D.

July 10, 1920 (Address) 5402 Chelton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Mt. Auburn Ave. July 12, 1920

20-UNDERTAKER

Simeon Hensley, M.D.

1044679 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 1044679
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 327 Warner - Mt. Winan ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Robert Day
(Residence in Baltimore: No. 327 Warner st St.; 1 yrs., mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, col
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH,

June 28, 1919
(Month) (Day) (Year)

7-AGE,

1 yrs. - 8 mos. ds.

If LESS than 1 day,
....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

nurse

9-BIRTHPLACE,
(State or Country).

balto md

PARENTS.

10-NAME OF FATHER,

Ellis Day

11-BIRTHPLACE OF FATHER
(State or Country),

va

12-MAIDEN NAME OF MOTHER

Hattie Lee

13-BIRTHPLACE OF MOTHER
(State or Country),

va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ellis Day

(Address)

327 Mt Winan

15-

Filed 11 1920

ROBERT B. LEAUTE

BALTIMORE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 9, 1920, to July 10, 1920,

that I saw him alive on July 7, 1920,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration)....yrs....mos....ds.

CONTRIBUTORY
(Secondary)

(Duration)....yrs....mos....ds.

(Signed) J. V. Egan M. D.

7/10, 1920 (Address) Baltimore, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn

DATE OF BURIAL,

Jan 11, 1920

20-UNDERTAKER

Mrs Robt a Elliott

ADDRESS

1725

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST.: *5* WARD)

REGISTERED NO. *1044680*
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Victoria Jones*

(a) RESIDENCE. NO. *1117 Mc Elderry St.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced—HUSBAND of (or) WIFE of *Frederick Jones*

6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE *40* Years Months Days If LESS than 1 day, hrs. or min.

6 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Washwoman*

(b) General nature of industry, business, or establishment in which employed (or employer) *Washwoman*

(c) Name of employer

9 BIRTHPLACE (city or town) *Washington* (State or country) *D. C.*

10 NAME OF FATHER *William Taylor*

11 BIRTHPLACE OF FATHER (city or town) *Do not know* (State or country)

12 MAIDEN NAME OF MOTHER *Louisa Taylor*

13 BIRTHPLACE OF MOTHER (city or town) *Unknown* (State or country)

14 Informant *Hospital Record* (Address) *J. H. H.*

15 JUL 11 1920 *LOREY E. LEADYER* Registrar *Burial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 9 1920*

17 I HEREBY CERTIFY, That I attended deceased from *July 5*, 19*20* to *July 9*, 19*20* that I last saw him alive on *July 9*, 19*20*, and that death occurred, on the date stated above, at *1:55 P.* m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Emphysema*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *Yes.*

What test confirmed diagnosis? *Autopsy*

(Signed) *W. Schumacher*, M. D.

(Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Laurel Cemetery *July 11 1920*

20 UNDERTAKER ADDRESS *1725-*

Mrs R. A. Elliott *Oakland*

Al

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1913 E. Lombard. ST.* WARD) *2*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

50 yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed or divorced, (or) WIFE of

George F. Voith.

6 DATE OF BIRTH (month, day, and year)

Aug. 7-1844

7 AGE

Years

Months

Days

*75**10**-*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Caspar D. Entz

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Regina Hebs

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

*Sophia Voith
E. Lombard St.*

15

JUL 11 1920

ROBERT E. KRAUTER
Registrar
Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 7 1920*

17

I HEREBY CERTIFY, That I attended deceased from *July 5 1920* to *July 6 1920*, that I last saw her alive on *July 6 1920*, and that death occurred, on the date stated above, at *11.40 P. m.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration)

yrs.

mos.

3 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

Maurice Feldman M. D.
7/10, 1920 (Address) 1802 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Cem.**July 12 1920*

20 UNDERTAKER

Lilly E. J. J. J.

ADDRESS

4038 N. 7th St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

1044682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

137

1044682

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 N. Ellwood Ave. ST. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary M. Matthew

(a) RESIDENCE. NO.

405 N. Ellwood Ave. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

4 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

James E. Matthew

6 DATE OF BIRTH (month, day, and year)

Feb. 28-1898

7 AGE

Years

22

Months

4

Days

11

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Co. Md.

10 NAME OF FATHER

John Schmidt.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germ any.

12 MAIDEN NAME OF MOTHER

Margaret Miguel.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germ any.

14

Informant (Address)

James E. Matthew 405 N. Ellwood Ave.

15

Filed JUL 19 1920

ROBERT A. ELLIOTT Registrar

Burial Permit 0122

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 9 1920

17

HEREBY CERTIFY, That I attended deceased from

June 18 1920, to July 9, 1920.

that I last saw her alive on July 9, 1920.

and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Septosemia following subcorneal

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

no

Did an operation precede death?

yes Date of June 17

Was there an autopsy?

no

What test confirmed diagnosis?

clinical

(Signed) A. A. Decker, M.D.

110, 1920 Address 2600 E. 11th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn Cem.

DATE OF BURIAL

July 15 1920

20 UNDERTAKER

Lilly & Zuber.

ADDRESS

403 S. Weymouth

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044683. HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

174 ✓ 1044683.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *1044683*)
2-FULL NAME *Paul Poglitzke*
(Residence in Baltimore: No. *810 S. Curley*)
REGISTERED NO. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
St.; *15* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*
4-COLOR OR RACE, *White*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
6-DATE OF BIRTH, *August 1893*
7-AGE, *26* yrs., *11* mos., ds.
8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Rigger*
(b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country), *Germany*
10-NAME OF FATHER, *Joseph Poglitzke*
11-BIRTHPLACE OF FATHER (State or Country), *Ger.*
12-MAIDEN NAME OF MOTHER, *unknown*
13-BIRTHPLACE OF MOTHER (State or Country), *Ger.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Mrs. Paul Poglitzke*
(Address) *810 S. Curley St.*

15-
Filed *JUL 11 1920*
ROBERT E. KRAUTH
Baptist Church Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 8, 1920*
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Empyema - due to punctured lung.
Caused by part of or nail.
Accidentally struck by a board.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *About 2 weeks*
(Duration) yrs. mos. ds.
(Signed) *M. J. Parley* M. D.
(Coroner)
July 11, 1920 (Address) *U.S. 9. Parley*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place *about 2 weeks* in the of death.... yrs.... mos.... ds. State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Sacred Heart Ch.*
20-UNDERTAKER, *Lilly and Ziehl*
DATE OF BURIAL, *July 12, 1920*
ADDRESS, *403 S. Wolfe St.*

1044684

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044684

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *22* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Jurgis Lankevicius

(a) RESIDENCE. NO.

**503 W. Pratt St.*

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. ds. How long in U. S., if of foreign birth? *10* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Single</i>
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5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*1868*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
52

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *unknown*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Lithuania*10 NAME OF FATHER *Adam Sankevicius*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Lithuania*12 MAIDEN NAME OF MOTHER *Versulevitch*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Lithuania*14 Informant *Mike Sankevicius*
(Address) *503 W. Pratt St.*

15

JUL 11 1920

ROBERT E. ELLIOTT Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 8* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

June 22, 19*20*, to *July 8*, 19*20*,that I last saw him alive on *July 8*, 19*20*,and that death occurred, on the date stated above, at *11:30 a.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus(duration) yrs. *6* mos. ds.CONTRIBUTORY *Broncho Pneumonia*

(Secondary)

(duration) yrs. mos. *3* ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

7/8, 19*20* (Address) *University Hospital*

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer Cem. July 12 1920

20 UNDERTAKER

ADDRESS

John Gebharts 425 S. Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

1044685

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

1044685

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

620 S. Bond

ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Antoni Bochnak

(a) RESIDENCE. NO.

620 S. Bond

ST. 3 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 3

mos. 7

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Apr 3/20

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt. Md.

10 NAME OF FATHER

Jacob Bochnak

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Austria

12 MAIDEN NAME OF MOTHER

Caroline Roschke

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Austria

14

Informant (Address)

Jacob Bochnak, 620 S. Bond St.

15

Filed

JUL 11 1920

ROBERT E. ELAETER Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

JUL 10 1920

17

HEREBY CERTIFY, That I attended deceased from July 6, 1920, to July 10, 1920, that I last saw him alive on July 10, 1920, and that death occurred, on the date stated above, at 5 P. m. The CAUSE OF DEATH* was as follows:

gastro-enteritis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 4 ds.

Congenital Weakness

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Stanislaus.

DATE OF BURIAL

July 11 1920

20 UNDERTAKER

M. J. Sadowski, 405 S. Ave

1044686

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 10 44686

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3920 Batzuman ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annis Ely Barrington

(Residence in Baltimore: No. 3920 Batzuman av St.; 65 yrs., 2 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female White

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

April 16, 1855 (Month) (Day) (Year)

7-AGE,

65 yrs., 2 mos., 23 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Nurse

9-BIRTHPLACE, (State or Country),

Baltimore Md

10-NAME OF FATHER

Edward A. Barrington

11-BIRTHPLACE OF FATHER (State or Country)

Hunttown Pa

12-MAIDEN NAME OF MOTHER

Jelia Furgis

13-BIRTHPLACE OF MOTHER (State or Country),

Ohio Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry H. Barrington

(Address) 3720 Batzuman av

15-

Filed JUL 11 1920

ROBERT R. KRAUTER

BUTAL PERMIT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 9, 1920 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 28, 1919 to July 9, 1920

that I saw her alive on July 8, 1920

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(Duration) 1 yrs. 9 mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs. 9 mos. 9 ds.

(Signed) M. D.

1920 (Address) 1733 Hollen St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bryn Mawr

July 12, 1920

UNDERTAKER

ADDRESS

J. J. J. J. J.

North Pa

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1044687 Municipal Tuberculosis Hospital ST. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Taylor(a) RESIDENCE. No. Brooklyn, Md.

ST. _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. _____ ds. _____ How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) 18987 AGE Years 22 Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Maryland
(State or country)10 NAME OF FATHER Jacob Taylor11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)12 MAIDEN NAME OF MOTHER Mary Dolby13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)14 Informant Hospital Records(Address) M.T.H.15 Filed JUL 11 1920 ROBERT F. ELLIS Registrar

Burial Permit 01071

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 192017 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1920 19____, to July 10, 19 20.that I last saw her alive on July 9, 19 20.and that death occurred, on the date stated above, at 7.10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) 1 yrs. 2 mos. _____ ds.CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? No Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? T.B. in sputum.(Signed) L. J. Rigney, M. D.7-10-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Furnace Branch 2200 July 11 192020 UNDERTAKER ADDRESS
JOHN F. DENNY 715 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

1044689 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044689

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Fluid Hill Park* CITY OF BALTIMORE (No. *13* ST.: *13* WARD) REGISTERED No. C. *4159*
 2-FULL NAME *L. G. Anderson* (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 (Residence in Baltimore: No. *108 Market Place* St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *M* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)
 6-DATE OF BIRTH, *Unknown*, 1 (Month) (Day) (Year)
 7-AGE, *50* yrs. mos. ds. If LESS than 1 day, hrs. or min.?
 8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Retired* (b) General nature of industry, business, or establishment in which employed (or employer) *086*
 9-BIRTHPLACE, (State or Country), *Unknown*
 10-NAME OF FATHER, *Unknown*
 11-BIRTHPLACE OF FATHER (State or Country), *Unknown*
 12-MAIDEN NAME OF MOTHER, *Unknown*
 13-BIRTHPLACE OF MOTHER (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. E. G. Anderson*
Back River, Rossville P.O., Md.

15-

Filed

JUL 11 1920

ROBERT B. KRAUTER

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 9*, 19*20* (Month) (Day) (Year)
 17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy, or inquiry.) find that said deceased came to *his* death on the day stated above.
 The CAUSE OF DEATH was as follows: *Gun shot wound through head (suicide)*
 (Duration) yrs. mos. ds.
 CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
 (Signed) *John H. Harrison* M. D. (Coroner)
July 10, 1920 (Address) *3632 Coladene*
 *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
 At place In the of death yrs. mos. ds. State yrs. mos. ds.
 Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, *Woodlawn Cemetery* DATE OF BURIAL, *July 11, 1920*
 20-UNDERTAKER, *H. E. Hughes* ADDRESS *17 N. Broadway*

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE

(No. *1103* *Hambert* ST. *24* WARD)

2-FULL NAME

Michael R. Gesalo

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE

(No. *1103* *Hambert* ST. *24* WARD)

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 18, 1918

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1 *4* *22* *21*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

John Gesalo

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Malenia Burdynski

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Malenia Gesalo 1103 Hambert St

JUL 12 1920

ROBERT B. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 10 1920

17

I HEREBY CERTIFY, that I attended deceased from *July 9*, 1920, to *July 10*, 1920, that I last saw him live on *July 9*, 1920.and that death occurred, on the date stated above, at *10 A.* m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis(duration) yrs. mos. *10* ds.

CONTRIBUTORY (Secondary)

Exhaustion(duration) yrs. mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *James H. Stroper* M. D.211, 1920 (Address) *346 E. 3rd St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Rosary**7/12 1920*

20 UNDERTAKER

William Giesowalski

ADDRESS

Eastern Ave.

CAUSE OF DEATH in plain terms, so that it may be properly translated into English. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 Archer ST.; 21 WARD)

2-FULL NAME

Edward Jerome Tucker

(a) RESIDENCE. NO.

606 Archer

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov, 22, 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

0718

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Refugee

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

James Ed. Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Richmond Virginia

12 MAIDEN NAME OF MOTHER

Rosena Wesley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Maryland

14

Informant (Address)

James Ed. Tucker 606 Archer St.

15

JUL 12 1920ROBERT E. FRANKLIN

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July, 10 1920

17

I HEREBY CERTIFY, That I attended deceased from

July, 7, 1920 to July 10, 1920that I last saw him alive on July 9, 1920and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Acute Sepsis Pneumonia(duration) — yrs. — mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

David Traubman, M. D.

Address)

122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

MT Auburn Ct.July 12 1920

20 UNDERTAKER

ADDRESS

J. H. Brown & Son 108 N. Montgomeryst

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

1044692

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044692

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mered Hospital* ST.: *20* WARD)REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)2-FULL NAME *Mrs. Ellen Kneest*(a) RESIDENCE. No. *2554 Hollins St*

ST. _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *16* yrs. *7* mos. *—* ds. How long in U. S., if of foreign birth? *20* yrs. *—* mos. *—* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *married*

6a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Herman Kneest*6 DATE OF BIRTH (month, day, and year) *Mar 24 1876*7 AGE Years Months Days *44* *1876* *4* *24* *17* LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Africa*
(State or country)10 NAME OF FATHER *William R. Harris*11 BIRTHPLACE OF FATHER (city or town) *England*
(State or country)12 MAIDEN NAME OF MOTHER *Alma Harris*13 BIRTHPLACE OF MOTHER (city or town) *England*
(State or country)14 Informant *Herman Kneest*
(Address) *2554 Hollins St*15 Filed *JUL 12 1920* *ROBERT E. LEATHER*Burial Permit *01000*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 11 1920*17 I HEREBY CERTIFY, That I attended deceased from *June 10*, 19 *20*, to *July 11*, 19 *20*, that I last saw him alive on *July 11*, 19 *20*, and that death occurred, on the date stated above, at *11:20* m. The CAUSE OF DEATH* was as follows:*In Reginaldson*

(duration) ? yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *J. O. Ridgely*, M. D.19 (Address) *Mered Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Green Park Cemetery July 14 1920*20 UNDERTAKER *H. B. Kneest 2136 Federal St* ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1044693

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. 1 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE Colored 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH May 27, 1920 (Month) (Day) (Year)

7-AGE 1 yrs. 13 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. JUL 12 1920 ROBERT E. KRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 10th, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1920, to July 10, 1920, that I saw him alive on July 10th, 1920, and that death occurred, on the date stated above, at 5 p.m. The CAUSE OF DEATH* was as follows: Bronchitis

Contributory (SECONDARY) Convulsions (Duration) yrs. mos. ds.

(Signed) F. W. Hartley-Helgeson M. D. July 11th 1920 (Address) 1204 W. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20-UNDERTAKER ADDRESS

1044694

HEALTH DEPARTMENT—CITY OF BALTIMORE

174 ✓ 1044694

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Mt. Royal apt. Mt Royal ave.*
 CITY OF BALTIMORE (No. *26* ST. *26* WARD)
 2-FULL NAME *Mr Ben Loff*
 (Residence in Baltimore: No. *3218 Hudson* St.; yrs., mos. ds.)

REGISTERED NO. C
 (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Man* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widower*
 6-DATE OF BIRTH, *Feb. 5, 1846*
 (Month) (Day) (Year)
 7-AGE *74* If LESS than 1 day,hrs. or....min.?
 yrs.mos.ds.

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work *Engineer*
 (b) General nature of industry, business, or establishment in which employed (or employer) *D 30*

9-BIRTHPLACE, (State or Country), *Balto*

PARENTS.
 10-NAME OF FATHER *Paul Ben Loff*
 11-BIRTHPLACE OF FATHER (State or Country), *Germany*
 12-MAIDEN NAME OF MOTHER *Unknown*
 13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) *B. Ben Loff*
 (Address) *3208 Hudson*

15- JUL 12 1920 101... ROBERT E. KRAUTER
 BIRTH PLACE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 9, 1920*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Skull - caused by falling down elevator shaft, a couple of days.
 (Duration)yrs.mos.ds.

CONTRIBUTORY (Secondary) *W.D. Miley* (Signed) *W.D. Miley* M. D. (Coroner.)
July 10, 1920 (Address) *1051 Bway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENCES)
 At place *Start coal* in the of deathyrs.mos.ds. Stateyrs.mos.ds.

Where was disease contracted, if not at place of deathf.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, *Oak Lawn Cem.* DATE OF BURIAL, *July 12 1920*
 20-UNDERTAKER *Joe J. Hen* ADDRESS *156 N. Luzerne ave.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044695

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044695

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2700 Chelsea Ave 15

ST.: WARD)

REGISTERED NO. C

2-FULL NAME

Cyrinthia Gregg

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

2700 Chelsea Ave

St.: yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

widow

6-DATE OF BIRTH,

Mch 17, 1846

(Month)

(Day)

(Year)

7-AGE,

84 3 23

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

retired

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Ohio

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER
(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Erminie N. Katherman

(Address).

2700 Chelsea Terrace

15-

Filed

JUL 12 1920

ROBERT E. KAUFER

BALTIMORE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 10, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 28, 1920, to July 10, 1920,

that I saw her alive on July 10, 1920,

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. 13 mos. ds.

CONTRIBUTORY
(Secondary)

Broncho pneumonia

(Duration) yrs. 13 mos. ds.

(Signed)

W. S. Webb

M. D.

July 10, 1920. (Address) 34026 6th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Ohio

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Goodman Cemetery July 12, 1920

20-UNDERTAKER

ADDRESS

J. M. Mitchell 1201 N. Fayette

CAUSE OF DEATH in plain terms, or terms as may be important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4010 Forest Park Ave.* ST.: *15* WARD)

2-FULL NAME

Leonard H. Durling

(a) RESIDENCE, NO.

4010 Forest Park Ave.

(Usual place of abode)

Length of residence in city or town where death occurred

30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

WARD.

(If nonresident, give city or town and State)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 10 1920

17 HEREBY CERTIFY, That I attended deceased from

July 2, 1920 to *July 10, 1920*that I last saw him alive on *July 10, 1920*and that death occurred, on the date stated above, at *1:30 P.m.*

The CAUSE OF DEATH* was as follows:

Acute Bronchitis(duration) yrs. mos. *10* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

A. H. Robinson M. D.*7/11, 1920* (Address)*1307 N. Charles St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park July 12, 1920

20 UNDERTAKER

John O. Mitchell 1201 W. Fayette

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Carrie Durling

6 DATE OF BIRTH (month, day, and year)

Oct - 1835

7 AGE

Years

Months

Days

*84**9**—*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

retired

(b) General nature of industry, business, or establishment in which employed (or employer)

School teacher

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ohio =

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Chas. R. Durling 4010 Forest Park Ave.

15

JUL 12 1920

ROBERT B. KRAUTER

Registrar

Bureau of Health

HEALTH DEPARTMENT—CITY OF BALTIMORE

102

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Thomas F. Allen

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/11/1920

17 1 HEBERY CERTLEY That I attended deceased from

July 10, 1920, to July 21, 1921

Oct. 19. 1851

and that death occurred, on the date stated above, at 12:22 a.m.

The CAUSE OF DEATH* was as follows:

ASED
Conductor B. R. R.

Myocarditis

(duration) yrs. mos. *12 mos.*

CONTRIBUTORY *Spinal cord stroke*

(Secondary)

(duration) yrs. mos. ds. *12 mos.*

Ja

Ed. F. Allen

Did an operation precede death? 22 Date of

(city or town) unknown

What test confirmed diagnosis?

Informant: *Thomas C. Allen*
(Address) *Phila. 104*

ROBERT S. MEUTERS

JUL 12 1920

Registrar

DATE OF BURIAL

Christiansburg Va. July 13, 02

ADDRESS

George J. Smith

100025.
2-7-58

N. B.—Every item of information should be carefully classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044698 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044698

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital
CITY OF BALTIMORE (No. 7 ST.: 7 WARD)
2-FULL NAME M. Pinkney Magness
(Residence in Baltimore: No. Hebrew Hospital St.; yrs., 0 mos. 1 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single
6-DATE OF BIRTH, About 1874
7-AGE, 46 ? ? If LESS than 1 day, ...hrs. or ...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work, Farmer (Self)
(b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country), Maryland
10-NAME OF FATHER, Albert Magness
11-BIRTHPLACE OF FATHER, (State or Country), Maryland
12-MAIDEN NAME OF MOTHER, Mary De Moss
13-BIRTHPLACE OF MOTHER, (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M. Dean Love
(Address) Bel-Air-Md

15- JUL 12 1920 ROBERT E. KRAUTER
Filed JUL 12 1920 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 11, 1920
17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.
Thereon and from the evidence obtained by said inquest, autopsy or inquiry, I find that said deceased came to death on the day stated above.
The CAUSE OF DEATH was as follows:
Traumatism
caused in finding
(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Signed) J. H. Gentry M. D.
2-12-1912 (Address) 48. Lee

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, 0 yrs. 0 mos. 1 ds. In the 46 ? ?
State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Bel-Air-Maryland
Former or usual residence Bel-Air-Md

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mountain Churchyard-Harford Co. Md. July 12/20
20-UNDERTAKER, STEWART & MOWEN COMPANY
ADDRESS 108 W. NORTH AVE.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044699

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 1044699

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 503 Cr. Castle St.
CITY OF BALTIMORE (No. 303 Cr. Castle St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Elizabeth Strohl (Strohl)
(Residence in Baltimore: No. 503 Cr. Castle St. St.; yrs., 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female
4-COLOR OR RACE, wh. Y.
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, May 24, 1853
(Month) (Day) (Year)

7-AGE, 65 yrs., 1 mos., 16 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housework
(b) General nature of industry, business, or establishment in which employed (or employer), at home

9-BIRTHPLACE, (State or Country), Germany

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant), Mrs. Strohl
(Address), 912 Fann St.

15- JUL 12 1920
Filed, 191. ROBERT E. TRAUTER
BALTIMORE, MD.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an...
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said...
(Inquest, autopsy or inquiry.)
and that said deceased came to... death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed), M. D.
(Coroner),
7-10, 1920 (Address),

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Schwartz Cem. July 12 1920
20-UNDERTAKER, ADDRESS
Philip Herwig Orleans St.

1044700

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044700

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 841 E Eager

ST. 10

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Edward Francis Healy

(Residence in Baltimore: No. 841 E Eager St.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

m

4-COLOR OR RACE,

w

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Lyle

6-DATE OF BIRTH,

7/11

24

1920

(Month)

(Day)

(Year)

7-AGE,

7 yrs. 11 mos. 11 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

John Healy

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Dorothy Wallen

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

John Healy

(Address),

841 E Eager St.

15-

Filed

JUL 12 1920

191

ROBERT F. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

7

11

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

7-7-1920, to 7-11-1920,

that I saw him alive on 7-10-1920,

and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Colitis

Inflammation

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. Senant Wilson M. D.

7-12-1920 (Address) 914 E. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral Cemetery

DATE OF BURIAL,

July 13, 1920

20-UNDERTAKER

Henry Wood Lee

ADDRESS

1301 E Eager St.

CAUSE OF DEATH in plain terms, as far as may be known, on back of certificate. important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 N. Eutan ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1112 N. Eutan St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH,

Sept 27, 1842 (Month) (Day) (Year)

7-AGE,

77 yrs., 9 mos., 13 ds.

If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

David Davidson

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Bertha Behrend

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

Filed...

JUL 12 1920

ROBERT E. ELAFTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 10, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1916, to July 10, 1920,

that I saw her alive on July 10, 1920,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) 12 yrs., mos., ds.

CONTRIBUTORY (Secondary)

Atherosclerosis, Myocarditis

(Duration) 14 yrs., mos., ds.

(Signed)

Louis P. Hunsicker, M. D.

July 12, 1920 (Address) 1207 E. Eutan St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore

DATE OF BURIAL,

July 12, 1920

20-UNDERTAKER

David Davidson

ADDRESS

1100 W. Eutan St.

1044702

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044702

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work.

(b) General nature of industry, busi-

ness, or establishment in which

employed (or employer).

9-BIRTHPLACE,

(State or Country),

10-NAME OF

FATHER,

11-BIRTHPLACE

OF FATHER

(State or Country),

12-MAIDEN NAME

OF MOTHER,

13-BIRTHPLACE

OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

JUL 12 1920

ROBERT F. KRAUTER

Filed

101

Baltimore Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH was as follows:

Gun shot wound of

heart

murder by her husband

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Signed)

1920 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER,

ADDRESS

1044703 HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 N. Gilmore ST.; 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1123 N. Gilmore St.; 70 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE.

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH.

(Month) April (Day) 16 (Year) 1883

7-AGE.

87 yrs. 2 mos. 2 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Carpenter (House)

9-BIRTHPLACE, (State or Country).

Sykesville, Md.

PARENTS.

10-NAME OF FATHER.

Benjamin Forester

11-BIRTHPLACE OF FATHER (State or Country).

Scotland

12-MAIDEN NAME OF MOTHER.

Ruth Elder

13-BIRTHPLACE OF MOTHER (State or Country).

Carroll, Co., Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary J. R. Forester

(Address) 1123 N. Gilmore St.

JUL 12 1920

ROBERT E. TRAUTER

191. BIRTH PLACE

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

(Month) July (Day) 11 (Year) 1920

17- I HEREBY CERTIFY, That I attended deceased from June 24 1920, to July 11 1920, that I saw him alive on July 11 1920, and that death occurred, on the date stated above, at 4:10 P. m. The CAUSE OF DEATH* was as follows:

Acute nephritis

(Duration) yrs. mos. ds. 17

CONTRIBUTORY (Secondary)

Uremic Coma

(Duration) yrs. mos. ds. 2

(Signed) E. C. Plummer M. D.

July 11, 1920 (Address) 539 N. F. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Manchester, England July 14, 1920

20-UNDERTAKER

J. M. Cook 502 E. North Ave.

1044704

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044704

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1813 Lemon

ST.: 19

WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Joseph A. Lucas

(Residence in Baltimore: No. 1813 Lemon

St.: yrs. 40 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH,

June 13, 1862
(Month) (Day) (Year)

7-AGE,

58 yrs. 26 mos. 26 ds.

If LESS than 1 day,
...hrs. or...min.

10-DATE OF DEATH,

July 9, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the
remains described above, held an
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said
(Inquest, au-opsy or inquiry.) and that said deceased came to death
on the day stated above.

The CAUSE OF DEATH was as follows:

Myocardial
infarction

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY
(Secondary)Chronic Pulmonary
(Duration) yrs. 6 mos. ds.(Signed) James M. Newell M. D.
(Coroner.)

July 11, 1920 (Address) 700 E. Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran-
sients, or Recent Residents).At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

15-

Filed

JUL 12 1920

101

ROBERT B. ERAUTER
Bureau of HealthLarchmont Park
7111 Locust 5026 North Ave

1044705 HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Church Home Infirmary

REGISTERED NO. C

CITY OF BALTIMORE: (No.

126 North Broadway

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Miss Marcella Phipps

(Residence in Baltimore: No.

25 Alleghany Ave, Towson

St.:

52 yrs.,

6 mos.

da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

December 11th, 1867

(Month)

(Day)

(Year)

7-AGE,

52

6

mos.

da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Towson, Md.

PARENTS.

10-NAME OF FATHER,

James Phipps

11-BIRTHPLACE OF FATHER
(State or Country),

London, England

12-MAIDEN NAME OF MOTHER

Josephine Hagle

13-BIRTHPLACE OF MOTHER
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Paris S. Phipps

(Address)

Towson, Md.

15-

Filed

JUL 12 1920

ROBERT E. KAUTER

BUTLER FAMILIAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 11

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 29, 1920, to July 11, 1920,

that I saw her alive on July 11, 1920,

and that death occurred, on the date stated above, at 12:00 noon

The CAUSE OF DEATH* was as follows:

Fibromata uteri

Fecal fistula (abdominal)

(Duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)

General Cachexia

(Duration) yrs. mos. da.

(Signed)

Ralph E. Swartz

M. D.

July 11, 1920 (Address) Church Home Inf.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. 12 da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Home

Former or usual residence

Towson, Md.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Presb. Church, Towson

July 13, 1920

20-UNDERTAKER

ADDRESS

John B. B. B. B.

Towson

CAUSE OF DEATH IN plain text, so that it may be important. See instructions on back of certificate.

1044706

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

JUL 12 1920

ROBERT E. KRAUTER
Registrar
Burial Permit

22

WARD)

ST.

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, that I attended deceased from May 8th, 1920, to July 8th, 1920, that I last saw him alive on July 7th, 1920, and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Nc

CONTRIBUTORY (Secondary)

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed)

7/8/20 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Mt Auburn Cemetery
R. & Gross 1405 McElderry

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

Monument St.

WARD)

6

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Leonard P. Siegel

(Residence in Baltimore: No.

214

N. Washington St.

St.;

yrs.,

9 mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH.

July 12

(Month)

(Day)

1918 (Year)

7-AGE.

2

yrs.

mos.

12

ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Balto Md

10-NAME OF FATHER,

Max Siegel

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Sarah Feinberg

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

M. Siegel

(Address)

214 N. Washington St.

15-

JUL 12 1920

ROBERT A. KLAUFER

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July

(Month)

11

(Day)

1920 (Year)

17-I HEREBY CERTIFY, That I attended deceased from

July 9 1920, to July 11 1920,

that I saw him alive on July 11 1920,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

General Septicemia - Organism still unknown

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

Osteomyelitis of left tibia

(Duration)....yrs....mos....ds.

(Signed) Charles J. Levy M. D.

7-11-20 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew Hospital

July 12, 1920

20-UNDERTAKER

ADDRESS 1127 E

Sol Thinson Balto Md

1044708

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044708

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis W. Mueller

2124 E. North Ave.

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Katherine Friskey

6 DATE OF BIRTH (month, day, and year)

Dec 17 - 1886

7 AGE

33

Years

6

Months

23

Days
If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Germany

10 NAME OF FATHER

William Mueller

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Ratsch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant
(Address)

Katherine Mueller
2124 E. North Ave

15

JUL 12 1920

ROBERT E. BLAUSTEIN
Registrar
Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 19 20

17

I HEREBY CERTIFY, That I attended deceased from July 6 19 20 to July 10 19 20

that I last saw him alive July 10 19 20

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Haemorrhage, intestinal

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Typhoid fever

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

No

Did an operation precede death? Date of

Was there an autopsy?

No

What test confirmed diagnosis? Physical signs

(Signed) J. B. Bronckhorst, M. D.

7-10, 1920 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cemetery

DATE OF BURIAL

July 12 1920

20 UNDERTAKER

J. Herwig & Co

ADDRESS

2008 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificates.

1044709

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044709

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *17* WARD)

2-FULL NAME

(a) RESIDENCE, No. *2210 Greenmount Ave*

(Usual place of abode)

Length of residence in city or town where death occurred *19* yrs. — mos. — ds.

WARD.

(If nonresident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Edna M. Lemmon

6 DATE OF BIRTH (month, day, and year)

May 19-1891

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*29**1**23*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

John H. Bellman

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

George S. Lemmon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Annie Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Geo S. Lemmon 1011 1/2 Grafton Ave

15

Filed

JUL 12 1920

ROBERT E. LEAUTEA

Burial Permit *OK*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 12-1920

17

I HEREBY CERTIFY, That I attended deceased from

*July 11-1920 to July 12-1920*that I last saw him alive on *July 12-1920*and that death occurred, on the date stated above, at *1 a.m.*

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction.(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

*yes*Date of *July 12-20*

Was there an autopsy?

no

What test confirmed diagnosis?

operation

(Signed)

E. S. Foster

M. D.

12, 1920 (Address)

Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Baltimore Cemetery**July 14-20*

20 UNDERTAKER

William D. O'Connell

ADDRESS

1723 1/2 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *14 Cereal*)ST.: *35* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

ROSIA GEMBICKI

(a) RESIDENCE NO.

14 Cereal

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb. 25-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4. 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House

(b) General nature of industry, business, or establishment in which employed (or employer)

" "

(c) Name of employer

" "

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Stanislaw Gembicki

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Antonina Gardeski

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Stanislaw Gembicki 14 Cereal St.

15

Filed

JUL 12 1920

ROBERT S. LAUTER

Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 11-1920

17

I HEREBY CERTIFY, That attended deceased from *July 10-1920* to *July 10-1920*, that I last saw him alive on *July 10-1920* and that death occurred, on the date stated above, at *9 A.M.*

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration)

Unknown

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

Thos. G. Fortson, M.D.

, 19

(Address)

Arden Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Cross**7/12 1920*

UNDERTAKER

ADDRESS

William Fialkowski Eastern

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificates.

D 44711

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 E. Elenmont ST. 24 WARD)

2-FULL NAME

Harry V. Glover

(a) RESIDENCE. NO. 1610 E. Elenmont ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (Write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed JUL 12 1920

ROBERT E. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from July 9th, 1920, to July 10th, 1920, that I last saw him alive on July 10th, 1920, and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Diarrhea & enteritis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Carmel Cemetery July 12 1920

20 UNDERTAKER

ADDRESS

E. J. Manning & Son, 1938 E. Lexington

TION is very important. See instructions on back of certificates.

1044712

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST.: 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Stewart(a) RESIDENCE. NO. 504 Peary St.

(Usual place of abode)

ST. 22 WARD.

Length of residence in city or town where death occurred

Unknown mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 18 53

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
67				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)10 NAME OF FATHER Joe Stewart11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)12 MAIDEN NAME OF MOTHER Julia Thompson13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14

Informant Hospital Records,(Address) New City Hospital.

JUL 12 1920

ROBERT B. BRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 192017 I HEREBY CERTIFY, That I attended deceased from February 20, 1915 to July 9, 1920that I last saw her alive on July 9, 1920and that death occurred, on the date stated above, at 7:05 P.m.

The CAUSE OF DEATH* was as follows:

Lupus Vulgarus(duration) 21 yrs. mos. ds.CONTRIBUTORY
(Secondary)Tubercular Pleurisy(duration) 2 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

unknownDid an operation precede death? no Date of

Was there an autopsy?

not as yet.

What test confirmed diagnosis?

(Signed) F. A. Holden, M. D.7-10, 1920 Address New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Wm. Auburn Cemetery7/12/1920

20 UNDERTAKER

ADDRESS

Charles B. Jones417 N. Pine St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed, 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

July 10, 1920, to July 10, 1920,

that I last saw him alive on July 10, 1920,

and that death occurred, on the date stated above, at 8:53 P. M.

The CAUSE OF DEATH* was as follows:

Septicæmia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 10, 20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ferdinand C. Lee, M. D.

, 19 (Address) Johns Hopkins Hosp. Balt. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary Cemetery July 13 1920

20 UNDERTAKER

ADDRESS

John M. Weber 1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. State statement of OCCASION is very important. See instructions on back of certificates.

JUL 12 1920

ROBERT A. TRAUTER
Burial Permit

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1228 N. Gay*ST.: *8* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *George Robt. Frost*(a) RESIDENCE. NO. *1228 N. Gay*

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *9* mos. *5* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct 7/19*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*9**5*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Balto*10 NAME OF FATHER *Edward M Frost*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto*12 MAIDEN NAME OF MOTHER *Margaret E. Sawyer*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Edw M. Frost 1228 N. Gay St.

15

Filed

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *7-12-1920*

17

I HEREBY CERTIFY, That I attended deceased from *June 4, 1920*, to *July 11, 1920*, that I last saw him alive on *July 11, 1920*, and that death occurred, on the date stated above, at *5:00 a.m.*

The CAUSE OF DEATH was as follows:

acute ill. Colitis(duration) yrs. *1* mos. ds.

CONTRIBUTORY (Secondary)

Bronchitis Pneumonia (duration) yrs. mos. *3* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

General signs

(Signed)

A. G. Hornstein

M. D.

7/12, 1920 (Address)

A. G. Hornstein

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral**July 12 1920*

20 UNDERTAKER

William Cook

ADDRESS

502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D. 44715

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44715

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1500 N. Fulton Ave ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Louise Chalmer

(a) RESIDENCE. NO.

1500 N. Fulton Ave ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

Chas. J. Chalmer

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66

3

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

mother is

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Donald Lemmering

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mary Fick

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Geo W. Little 1500 N. Fremont

15

Filed

JUL 12 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

7-11-1920

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1920, to July 11, 1920.

that I last saw her alive on July 11, 1920.

and that death occurred, on the date stated above, at 4.4 p. m.

The CAUSE OF DEATH* was as follows:

Coronary aneurysm of spleen.

(duration) yrs. 6 mos. 10 ds.

CONTRIBUTORY (Secondary)

Surgery

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) James A. McLaughlin M. D.

, 19 (Address) 1303 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park

July 14 1920

20 UNDERTAKER

Geo W. Little

ADDRESS

531 W. Fremont

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.; 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUL 12 1920

Robert P. Harrison,

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

July 11, 1920, to July 11, 1920, that I saw her alive on July 11, 1920,

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary)

(Duration) yrs. 6 mos. da.

(Signed) M. D.

7/12/20, 1920 (Address) 865 N. 30th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Greenmount

7-13, 1920

20-UNDERTAKER

ADDRESS

W. Krausk & Son

703 Newover

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* ST. *18* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *Child's Nursery & Hospital* ST. *18* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *1*mos. *29*ds. *29*

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 12-1919

7 AGE

Years

Months

Day

If LESS than 1 day, hrs. or min.

*1**1**29*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Thomas Covington

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Effie Painter

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Miss Rhinehart. Jewell Court.

15

Filled

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

7-10

19

17

I HEREBY CERTIFY, That I attended deceased from

July 10, 1920, to July 10, 1920,
that I last saw him live on *July 10, 1920,*and that death occurred, on the date stated above, at *9:05 P. m.*

The CAUSE OF DEATH* was as follows:

Nasal, Diphtheria (tonsillar, pharyngeal, laryngeal.)
(duration) *5* yrs. *5* mos. *5* ds.

CONTRIBUTORY (Secondary)

none.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

*at home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

Positive diphtheria culture.

(Signed)

B. Macgowan.

M. D.

7/11/1920 Address)

Sydenham Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cremated at J. H. H.**12*

19

20 UNDERTAKER

ADDRESS

Commissioner Health,

JUL 12 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Ransom(a) RESIDENCE. No. 204 S. Spring St.

ST. _____ WARD _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S. if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

Colored

Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 1874

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

46

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)10 NAME OF FATHER George Ransom11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)12 MAIDEN NAME OF MOTHER Mary Thomas July 8, 192013 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14

Informant
(Address)Hospital Records,New City Hospital.Robert F. Harrison,

Registrar

15

JUL 12 1920Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1920

17

I HEREBY CERTIFY, That I attended deceased from
June 25, 1920, to July 8, 1920.that I last saw him alive on July 7, 1920.and that death occurred, on the date stated above, at 5:50 A.M.

The CAUSE OF DEATH* was as follows:

Appendicitis(duration) yrs. mos. 14 ds.CONTRIBUTORY
(Secondary)(duration) yrs. mos. 1 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? Yes Date of June 28, 1920

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Holden, M. D.(Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner Health,

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bidley Sanatorium* ST.; *12* WARD)

REGISTERED NO. C _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Joseph V. Pryor*(Residence in Baltimore: No. *337 E 21 St* St.; *12* yrs., *12* mos., *12* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE *Married*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH, *Jan 20, 1852*

(Month)

(Day)

(Year)

7-AGE, *68* yrs., *1* mos., *15* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Carriage Painter*(b) General nature of industry, business, or establishment in which employed (or employer) *85*9-BIRTHPLACE,
(State or Country), *Balti City*10-NAME OF FATHER, *Alford V. Pryor*11-BIRTHPLACE OF FATHER
(State or Country), *Balti City*12-MAIDEN NAME OF MOTHER *Martha White*13-BIRTHPLACE OF MOTHER
(State or Country), *Balti City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Paul Geseford*(Address) *103 Wyndhurst*

15-

JUL 12 1920

Robert P. Harrison,

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 10, 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 9, 1920*, to *July 10, 1920*,that I saw him alive on *July 10 - 6 PM, 1920*,and that death occurred, on the date stated above, at *2:00 PM*.

The CAUSE OF DEATH* was as follows:

Strangulated hernia.
Right Inguinal(Duration) *3* yrs., *3* mos., *3* ds.CONTRIBUTORY (Secondary) *Auto intoxication + operation*(Duration) *3* yrs., *3* mos., *3* ds.(Signed) *H. H. Stanchbury* M. D.*July 12, 1920* (Address) *714 Park Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *12* yrs., *12* mos., *12* ds. In the State *12* yrs., *12* mos., *12* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Balti Cemetery*DATE OF BURIAL, *July 15, 1920*20-UNDERTAKER *H. H. Marshall*ADDRESS *3839 Falls Rd*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *503 E. 23rd*)ST. *9*

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John H. Fridinger*(Residence in Baltimore: No. *503 E. 23rd*)St.; *18* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>male</i>	4-COLOR OR RACE, <i>white</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>married</i> (Write the word.)
6-DATE OF BIRTH, <i>march 22, 1848</i> (Month) (Day) (Year)		
7-AGE, <i>72</i> yrs. <i>3</i> mos. <i>19</i> ds.		8-If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work, <i>Engineer</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>030</i>		

9-BIRTHPLACE,
(State or Country)*Hagerstown Md*

PARENTS.

10-NAME OF FATHER,

*unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Germany*

12-MAIDEN NAME OF MOTHER

*unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Nellie Fridinger*(Address) *503 E. 23rd St.*

15-

*JUL 12 1920**Robert P. Harrison,*

Registrar.

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 11, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 11, 1920*, to *July 11, 1920*, that I saw him alive on *July 10, 1920*, and that death occurred, on the date stated above, at *6 a. m.*

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis
Softening of brain
(Duration) *3* yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Age
(Signed) *Wm T. Watson* M. D.
July 12, 1920 (Address) *212 St Paul*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Hagerstown Md

DATE OF BURIAL,

July 13, 1920

20-UNDERTAKER

Chas. G. Black 742 W. North Ave

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

0.44722

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

0.44722

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 749 St. Peter St.

ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ellis Orem

(a) RESIDENCE. No. 749 St. Peter St.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24. 1920

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

10 NAME OF FATHER Wilbert V. Orem

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Lydie M. Pitcher

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Wilbert V. Orem (Address) 749 St. Peter St.

JUL 12 1920

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1920

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1920, to July 12, 1920,

that I last saw him alive on July 11, 1920, and that death occurred, on the date stated above, at 2:30 A. M.

The CAUSE OF DEATH* was as follows:

Quinilia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? 20 Date of

Was there an autopsy? 20

What test confirmed diagnosis? 20

(Signed) J. M. Lempert, M. D.

19 (Address) 626 N. Barrallan

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park Cemetery.

7/13/20

20 UNDERTAKER

Joseph B. Cook

ADDRESS

1003 N. Balto Street

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.44723

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5332 Carrollton Ave ST.; 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 5332 Carrollton Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX

Male

4-COLOR OR RACE,

White

5-STATUS

MARRIED,

WIDOWED,

OR UNMARRIED,

(Write the word.)

6-DATE OF BIRTH,

November 21st, 1861
(Month) (Day) (Year)

7-AGE,

58 yrs. 7 mos. 21 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Marble Cutter

9-BIRTHPLACE,
(State or Country).

Baltimore Md

10-NAME OF FATHER,

Patrick Neville

11-BIRTHPLACE OF FATHER
(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Catherine Aspell

13-BIRTHPLACE OF MOTHER
(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert P. Harrison*
(Address) *201 N. Carrollton Ave*

15-

Robert P. Harrison,

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 12th, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 1920, to July 12th 1920, that I saw her alive on July 10th 1920, and that death occurred, on the date stated above, at 10.9 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis,
by pericarditis.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) 3 yrs. mos. ds.

(Signed) *Robert P. Harrison* M.D.July 12, 1920. (Address) *201 N. Carrollton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

20-UNDERTAKER

Banning Bros.

DATE OF BURIAL,

July 15, 1920

ADDRESS

517 N. Schneider St.

JUL 12 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2014 E Fayette ST.; 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2014 E Fayette St.; yrs., mos. (..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, July 10, 1920
(Month) (Day) (Year)

7-AGE, 7 hours If LESS than 1 day, 7 hrs. or min.?
..... yrs. mos. ds.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

10-NAME OF FATHER, John V Stewart

11-BIRTHPLACE OF FATHER (State or Country), Bd Maryland

12-MAIDEN NAME OF MOTHER Sadie F. Carr

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John V Stewart

(Address) 2014 E Fayette St.

15-

Robert P. Harrison,

JUL 12 1920

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 191....., to..... 191.....,

that I saw him alive on July 10, 19120,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

.....
.....
..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY Congenital atelectasis
(Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) Frank H. Hays M. D.
July 10, 19120 (Address) 2005 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hog Creek Cemetery DATE OF BURIAL, 7/12/20

20-UNDERTAKER, J. G. Moran ADDRESS, 3000 E. Baltimore

D. 44725

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

D. 44725

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 London Avenue ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Catherine Bammon(a) RESIDENCE. No. 102 London Avenue ST. 20 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, ~~divorced~~ Married

(or) WIFE of

James Bammon6 DATE OF BIRTH (month, day, and year) Nov. 18697 AGE Years 50 Months 7 Days 1869 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)10 NAME OF FATHER David Robinson11 BIRTHPLACE OF FATHER (city or town) Ellicott City Md
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14

Informant
(Address)Joseph Bammon
102 London Avenue Baltimore

15

Robert P. Harrison,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 22, 1920, to July 10, 1920,that I last saw her alive on July 17, 1920,and that death occurred, on the date stated above, at 8:40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis(duration) 8 yrs. 8 mos. 8 ds.CONTRIBUTORY
(Secondary)(duration) 8 yrs. 8 mos. 8 ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel H. Harrison, M. D., 19 (Address) Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral CemeteryJuly 13 1920

20 UNDERTAKER

M. D. Flynn

ADDRESS

1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

JUL 12 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

415 Hanover

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Cora Goodrick

(a) RESIDENCE, NO.

415 Hanover

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

18 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 27, 1901

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

18

8

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

A. A. Co. Md

10 NAME OF FATHER

Henry Goodrick

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Washington D. C.

12 MAIDEN NAME OF MOTHER

Bertha Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Mrs. Bertha Tilghman 415 Hanover St.

15

File

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 10, 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 1, 1920, to July 10, 1920,

that I last saw him alive on July 9, 1920,

and that death occurred, on the date stated above, at 8:00 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cedar Hill Cem.

20 UNDERTAKER

M. L. Flynn

DATE OF BURIAL

July 13, 1920

ADDRESS

1422 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

JUL 12 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3706 Clifton Ave* ST.; *15* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *3706 Clifton Ave* St.; *74* yrs., *8* mos., *27* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*white*5-SINGLE, *Widow*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

October 14, 1845
(Month) (Day) (Year)

7-AGE,

*74 yrs., 8 mos., 27 ds.*If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*at home*9-BIRTHPLACE,
(State or Country),*Maryland.*

10-NAME OF FATHER,

*Stephen Lynch*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Elizabeth Stewart*13-BIRTHPLACE OF MOTHER
(State or Country),*Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Abbott (niece)*(Address) *705 Woodbourne Ave. (Gowans)*

15-

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 11, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *June 17 1920*, to *July 11 1920*, that I saw her alive on *July 11 1920*, and that death occurred, on the date stated above, at *2:45 P.m.*

The CAUSE OF DEATH*, was as follows:

*Chronic Diffuse Nephritis
Mitral Regurgitation*(Duration) *1 yr.* mos. ds.CONTRIBUTORY
(Secondary)*Uraemic Coma*(Duration) *3 d.*(Signed) *R. C. Ingham* M. D.*July 12, 1920* (Address) *1903 E. E. Smith St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *74 yrs.* mos. ds. In the State *74 yrs.* mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Greenmount Cemetery July 14, 1920

20-UNDERTAKER

ADDRESS

H. C. Hughes 17 Broadway

JUL 12 1920

1044728

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044728

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Women's Hospital*

REGISTERED No. C

CITY OF BALTIMORE: (No. *834 of Gay St*)ST.; *10* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME *Maryth Tyler Levy*(Residence in Baltimore: No. *834 of Gay St*)St.; *8th* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *white* 5-STATUS, *MARRIED, married*
OR WIDOWED
OR DIVORCED
(Write the word.)6-DATE OF BIRTH, *August 22, 1898*
(Month) (Day) (Year)7-AGE, *22* yrs., mos. ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *Thomas Tyler*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Nannie Simms*13-BIRTHPLACE OF MOTHER (State or Country), *Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sylvan Levy*(Address) *834 of Gay St*

15-

JUL 13 1920 ROBERT E. KRAUTER

Filed..... 191... BUREAU OF VITALS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 12, 1920*
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *July 8, 1920* to *July 12, 1920*, that I saw her alive on *July 12, 1920*, and that death occurred, on the date stated above, at *5:20 a.m.*The CAUSE OF DEATH* was as follows:
Peritonitis following acute appendicitis
(Duration)..... yrs..... mos..... ds. *6*CONTRIBUTORY (Secondary).....
(Duration)..... yrs..... mos..... ds.(Signed) *James S. Speed* M. D.
July 12, 1920 (Address) *Women's Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos. *5* ds. In the State..... yrs..... mos..... ds.Where was disease contracted, if not at place of death? *1112 E. Monument St*Former or usual residence *1112 E Monument St*19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *Baltimore* *July 14, 1920*20-UNDERTAKER ADDRESS *Henry Jenkins, 1000 N. Holladay St*

CAUSE OF DEATH in plain terms, so that it may be properly examined. Print name of informant. See instructions on back of certificate.

1044729 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044729
54

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 N Washington ST. 6 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 423 N Washington ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

4 yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 14 - 1884

7 AGE

36

Months

4

28

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Mariner

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Fairmount Md

10 NAME OF FATHER

Geo T. Holland

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Fairmount Md

12 MAIDEN NAME OF MOTHER

Victoria O. Raskin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Fairmount Md

14

Informant
(Address)Victoria Holland
423 N Washington

15

Filed JUL 13 1920

ROBERT K. KRAUTER

Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 12 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 1920, to July 12, 1920,

that I last saw him alive on July 12, 1920,

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Pericarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Ayer, M. D.

19. (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Fairmount Md

DATE OF BURIAL

July 13 1920

20 UNDERTAKER

J. Herwig & Co

ADDRESS

2005 E. Monument St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3624 Creamore Ave. St. 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth McKelvey Partside(Residence in Baltimore: No. 3624 Creamore Ave. St. 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-STATUS Widowed
(Write the word.)6-DATE OF BIRTH, May 13, 1830
(Month) (Day) (Year)7-AGE, 90 yrs. 1 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
- None
-
- (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Hybrid Co. Md.10-NAME OF FATHER, Thomas Armstrong11-BIRTHPLACE OF FATHER (State or Country), Scotland12-MAIDEN NAME OF MOTHER, Catherine Smith13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Partside(Address) 3624 Creamore Ave.

15- JUL 13 1920

Filed 191 ROBERT F. FRANTZ Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 11, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 24, 1920, to July 11, 1920, that I saw her alive on July 11, 1920, and that death occurred, on the date stated above, at 5:30 PM. The CAUSE OF DEATH* was as follows:Acute Pericarditis of Long Course
of heart exhaustion
(Duration) 4 hoursCONTRIBUTORY arteriosclerosis
(Secondary)(Duration) 10 yrs. 0 mos. 0 ds.(Signed) A. Reley M. D.July 12, 1920 (Address) 3842 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Union RidgeDATE OF BURIAL, July 14, 192020-UNDERTAKER, A. MarshallADDRESS, 3539 Fall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter statement on back of certificate. important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1124 McCulloh* ST. *11* WARD)2-FULL NAME *Sarah Elizabeth Dunnett*(Residence in Baltimore: No. *1124 McCulloh* St.; *28* yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)

6-DATE OF BIRTH, *Feb 20*, 18*92*
(Month) (Day) (Year)

7-AGE *78* yrs. *4* mos. *22* ds. If LESS than 1 day,hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore Md*

10-NAME OF FATHER, *Henry Hush*

11-BIRTHPLACE OF FATHER (State or Country), *Md*

12-MAIDEN NAME OF MOTHER *Hannah Foraythe*

13-BIRTHPLACE OF MOTHER (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm W. Dunnett*(Address) *1124 McCulloh St*

15-

ROBERT E. BRADY

Filed

JUL 13 1920

101.

ROBERT E. BRADY Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 11*, 19*20*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 3* 19*20*, to *July 11* 19*20*, that I saw her alive on *July 10* 19*20*, and that death occurred, on the date stated above, at *2:30* p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Hypostatic)

(Duration).....yrs.....mos.....ds.
CONTRIBUTORY *Arteriosclerosis general*
(Secondary) *several*

(Duration).....yrs.....mos.....ds.

(Signed) *L W Keown* M. D.

July 12, 1920 (Address) *1938 Linden Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL, *July 13, 1920*

Greenmount Co

20-UNDERTAKER ADDRESS

Chas E. French 807 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Place statement of OCCUPATION in 8. Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D44732

35 D44732

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 Parish

ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Essie Wallace

(a) RESIDENCE. NO. 1126 Parish

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female Colored Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 12, 1902

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

17 9 29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

Folder

(c) Name of employer

Regal Laundry

9 BIRTHPLACE (city or town) (State or country)

Baltimore Co. Md.

10 NAME OF FATHER

William Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Chester Co. Pa.

12 MAIDEN NAME OF MOTHER

Fancy Keel

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

York Co. Pa.

14

Informant (Address)

William Wallace 1126 Parish St.

15

Filed

JUL 13 1920

ROBERT E. KRAUTER Registrar

Burial Permit 5444

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 11 1920

17

HEREBY CERTIFY, That I attended deceased from

Sept 10, 1920, to July 11, 1920,

that I last saw her alive on July 10, 1920,

and that death occurred, on the date stated above, at 9:45 A. M.

The CAUSE OF DEATH* was as follows:

General Tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Not known

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

None

(Signed)

William Frey, M. D.

7/11, 1920 Address)

1920 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn July 14 19

20 UNDERTAKER

JAMES H. DENNIS

ADDRESS

1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

— 59 —

244733

91-2 44733

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 10, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said.....
(Inquest, au-
topsy or inquiry).....and that said deceased came to.....death
on the day stated above.
The CAUSE OF DEATH* was as follows:

..... (Duration) yrs. mos. 2 da.
CONTRIBUTORY No history of other disease
(Secondary)

..... (Duration) hrs. min. sec.
(Signed) J. T. Hennessy M. D.
..... (Coroner.)
July 10 1910 (Address) 2802 Edmundson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death....yrs....mos....da. State....yrs....mos....da.

19-PLACE OF BURIAL OR REMOVAL, <i>St. Peters</i>	DATE OF BURIAL, <i>July 13 1920</i>
20-UNDERTAKER JAMES H. DENNIS	ADDRESS

1303 PRESTMAN ST.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3 Cherry (Curtis Bay)*;

REGISTERED No. C

WARD) *25*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Joseph Gostlowicz*(Residence in Baltimore: No. *3 Cherry St*

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH,

*Oct**7**1917*

(Month)

(Day)

(Year)

7-AGE,

*2**9**5*If LESS than 1 day,
hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*None*9-BIRTHPLACE,
(State or Country),*Curtis Bay*

PARENTS.

10-NAME OF FATHER,

*Vincent Gostlowicz*11-BIRTHPLACE OF FATHER
(State or Country),*Poland*

12-MAIDEN NAME OF MOTHER

*Michalina Swabowska*13-BIRTHPLACE OF MOTHER
(State or Country),*Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Vincent Gostlowicz*(Address) *3 Cherry St*

15-

JUL 13 1920

ROBERT E KRAUTER

Filed..... 191..

BRIAN FRYMONT

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*July**15**1917*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 6 1917, to *July 10* 1917,that I saw her alive on *July 12* 1917,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *William S. Scott* M. D.*July 17* 1917 (Address) *806 Pennsylvania*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

St Stanislaus Bene *July 14* 1917

20-UNDERTAKER

ADDRESS

Stephen Biackowski *1000 E. Genesee*

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044736

No 44736

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1127 N. Carey St.

ST. 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1127 N. Carey St.

St. 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Cauc

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

16-DATE OF DEATH,

July 10, 1920 (Month) (Day) (Year)

6-DATE OF BIRTH,

Unknown, 1878 (Month) (Day) (Year)

7-AGE,

42 yrs. mos. ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Domestic

9-BIRTHPLACE, (State or Country),

Washington D.C.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Walter B. Bader

(Address)

1127 N. Carey St.

15-

JUL 13 1920

ROBERT E. EBAUTER

Filed..... 191.....

BALTIMORE CITY

MEDICAL CERTIFICATE OF DEATH.

I HEREBY CERTIFY, That I attended deceased from July 2, 1920, to July 10, 1920, that I saw her alive on July 10, 1920, and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

Right Hemiplegia

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed) W. J. Coleman

July 12, 1920 (Address) 239 McCall St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn

DATE OF BURIAL,

July 13, 1920

20-UNDERTAKER

Sam N. Chase

ADDRESS

1400 Mosher

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044737

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044737

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *54 Ave Colgate* ST.: *26* WARD)2-FULL NAME *Juliana Kunkel*(a) RESIDENCE. NO. *54 Ave Colgate* ST., WARD.

(Usual place of abode)

(If nonresident give city and town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *George L. Kunkel* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *Dec. 11-1854*7 AGE Years *63* Months *6* Days *28* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife* 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto* (State or country) *Maryland*10 NAME OF FATHER *Jacob Bucher*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Charlotte Schaefer*13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)14 Informant *George L. Kunkel* (Address) *54 Ave Colgate*15 Filed *JUL 13 1920* ROBERT E. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 11* 19*20*17 I HEREBY CERTIFY, That I attended deceased from *April 29*, 19*20*, to *July 11*, 19*20*, that I last saw him alive on *July 10*, 19*20*, and that death occurred, on the date stated above, at *6:15 P. M.*

The CAUSE OF DEATH* was as follows:

Cancer (Uterine)(duration) *3* yrs. *3* mos. *—* ds.CONTRIBUTORY *Dropsy (abdominal & lower limbs)* (Secondary)(duration) *2* yrs. *—* mos. *—* ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *John H. Rehberger* M. D., 19 (Address) *1709 Alameda St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Catharone Cemetery *July 14 1920*

20 UNDERTAKER ADDRESS

H. Sander Sons *1210 Plunk*Physicians should be stated EXACTLY. Exact statement of OCCUR-
mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUR-
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

1044738

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044738

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2625 Fair Ave ST.: 26 WARD)

2-FULL NAME

Margaret Nicoll(a) RESIDENCE. NO. 2625 Fair Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry E. Nicoll6 DATE OF BIRTH (month, day, and year) Nov. 15, 18757 AGE Years 44 Months 7 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Maryland10 NAME OF FATHER John Fisher11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Elizabeth Smith13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant (Address) Harry E. Nicoll 2625 Fair Ave15 Filed JUL 13 1920 19 ROBERT E. ERAUTER Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

26

WARD)

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 192017 I HEREBY CERTIFY, That I attended deceased from June - 5, 1920, to July - 10 - 20that I last saw him alive on July 10, 1920and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis -(duration) yrs. 2 mos. ds.CONTRIBUTORY (Secondary) Quinsy & Larynx(duration) yrs. mos. 7 ds.18 Where was disease contracted ☒ if not at place of death?Did an operation precede death? no Date of ☒Was there an autopsy? noWhat test confirmed diagnosis? usual(Signed) Imperatore, M. D.12/7 1920 Address) 125 S Broadway -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount CarmelJuly 14 1920

20 UNDERTAKER

ADDRESS

H. Sander & Sons1700 Park

Physicians should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

1044739

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1044739

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

415 Lewis

ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elder James

(a) RESIDENCE. No.

415 Lewis

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7

4 COLOR OR RACE

Cul

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Thos James

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Thos James

415 Lewis

15

Filed

19

JUL 13 1920

ROBERT A. ELLIOTT

Registrar

BRIEF STATEMENT OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 11 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 1, 1920, to July 11, 1920

that I last saw h. alive on July 10, 1920

and that death occurred, on the date stated above, at 3:45 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Lung

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

Pneumonia (duration) yrs. 2 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. C. Burns, M. D.

21, 19 (Address) 22-103-104

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Asbury Cemetery July 13 1920

20 UNDERTAKER

ADDRESS

Harry A. Odery 1735 Orleans St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* 7

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Columbus Sutton*(a) RESIDENCE. NO *Norman Park, Ga.* WARD. *Norman Park Ga.*
(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 ~~Single~~ Married, Widowed, or Divorced (write the word) *married*5a If married, widowed, or divorced HUSBAND of *Anna Sutton* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *Aug 27-1882*7 AGE *38* Years *10* Months *15* Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Railroad work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Georgia* (State or country)10 NAME OF FATHER *Jacob L. Sutton*11 BIRTHPLACE OF FATHER (city or town) *Georgia* (State or country)12 MAIDEN NAME OF MOTHER *Martha Roberts*13 BIRTHPLACE OF MOTHER (city or town) *Georgia* (State or country)14 Informant *Hospital Record* (Address) *J. H. H.*15 Filed *JUL 13 1920* 19 *ROBERT E. KAUTER* Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 12* 19 *20*17 I HEREBY CERTIFY, That I attended deceased from *July 6*, 19 *20*, to *July 12*, 19 *20* that I last saw *him* alive on *July 12*, 19 *20*, and that death occurred, on the date stated above, at *5-30* p. m.

The CAUSE OF DEATH* was as follows:

Cerebello-pontine angle tumor(duration) *4* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted *Georgia (Rome)* if not at place of death?Did an operation precede death? *yes* Date of *7/12/20*Was there an autopsy? *yes*What test confirmed diagnosis? *operation*(Signed) *J. H. Kerr* M. D., 19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Tifton Ga

20 UNDERTAKER

Jack Lewis

DATE OF BURIAL

July 13 1920

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. It is important that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19-H. P. Co.-1000 Ills.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

244741

30 244741

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes' Hospital*)

2-FULL NAME

Catherine Kahler

(a) RESIDENCE. NO.

St. Vincent's Infant Asylum

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 1918

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2 yrs

also 3

not known

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Infant

9 BIRTHPLACE (city or town) (State or country)

Ind

10 NAME OF FATHER

John J. Kahler (decd)

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Co

12 MAIDEN NAME OF MOTHER

Anna Doerfler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Co

14

Informant (Address)

St. Vincent's Infant Asylum 1401 Division St.

15

DATE

JUL 13 1920

ROBERT E. REASTER

Barrel Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

7-12 1920

17

I HEREBY CERTIFY, That I attended deceased from

7-11 1920, to *7-12 1920*

that I last saw her alive on *7-12 1920*

and that death occurred, on the date stated above, at *9:30 a.m.*

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(duration) yrs. mos. *10* ds.

CONTRIBUTORY (Secondary) *Coma + Exhaustion*

(duration) yrs. mos. *2* ds.

18 Where was disease contracted if not at place of death? *Not known*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *E. H. Adams*, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

July 14 1920

20 UNDERTAKER

Lilly & Ziller

ADDRESS

403 S. Wolfe St

W44742 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 S. Chester ST.: 1 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 513 S. Chester ST.: 1 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 18 1890 7 AGE Years 29 Days 7 If LESS than 1 day, hrs. 5 or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Elias M. Dougall11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.12 MAIDEN NAME OF MOTHER Cattie Murdock13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.14 Informant Mary E. Murdock (Address) 513 S. Chester St.

JUL 13 1920 ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 192017 I HEREBY CERTIFY, That I attended deceased from June 5 1920 to July 12 1920that I last saw the deceased on July 12 1920and that death occurred on the date stated above, at 248 P. m.The CAUSE OF DEATH was as follows: PneumoniaCONTRIBUTORY (Secondary) 7. 13 B. ailer (duration) 9 yrs. mos. ds.18 Where was disease contracted if not at place of death? Dr. KnewDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Tuberculin Reaction (Signed) Edmund B. Decker M. D., 19 (Address) 2432 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Patrick's Church July 14 1920

20 UNDERTAKER Lilly & Zeller ADDRESS 400 S. Wolfe St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 15 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

male

Colored

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 11-1920

7 AGE

Years

Months

Days

If LESS than 1 day, 18 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Henry Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Durham North Carolina

12 MAIDEN NAME OF MOTHER

Cassie Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Lynchburg Virginia

14

Informant (Address)

Henry Richardson 1734 Baker St

JUL 13 1920

ROBERT B. BRADLEY
Basis Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 12th 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 11, 1920, to July 12, 1920,

that I last saw him alive on July 12, 1920,

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. N. Douglas, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Peters

July 13 1920

20 UNDERTAKER

ADDRESS

Edw. Ringgold

1463 Cayne

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

944744 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.: yrs., 6, mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I, took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

opsy or inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns (body) accidental.
Bed set a fire, cause unknown

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Hemmery M. D.

(Coroner.) July 10, 1920 (Address) 2802 Edgemoor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Md. Gen. Hosp. In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 557 Orchard St.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mount Auburn Cemetery Aug. 13, 1920

20-UNDERTAKER ADDRESS

John H. Toddner 1424 Hill St.

1044745

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044745

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Boydale Rd. 13 WARD)

2-FULL NAME John B. Singleton

(a) RESIDENCE No. 1715 Boydale Rd.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed,
or Divorced (write the word)

Married

5a If married, widowed, or divorced,
HUSBAND of
(or) WIFE of

Mary Martin

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

60

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Retired

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Dealer

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

Wm. B. Singleton

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Martin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Ireland

14

Informant
(Address)Mary B. Singleton
1715 Boydale Rd.

15

File

JUL 13 1920

ROBERT E. KAUTER
Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 10th, 1920, to July 11, 1920,

that I last saw him alive on July 11, 1920,

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Largimona Liver &
Stomach

do not know (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) H. J. Carriker, M.D.

July 12 1920 (Address) 412 N. Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicide, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Ave

7/14 1920

15 UNDERTAKER

ADDRESS

F. J. Carriker

1715 Boydale Rd.

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D. 44746 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3609 Sycamore ST. 13 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 3609 Sycamore ST. 13 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. - mos. - ds.

How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Buffington

6 DATE OF BIRTH (month, day, and year) Aug. 22-1858

7 AGE Years 61 Months 10 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hartford Conn. Maryland

10 NAME OF FATHER Joseph Burkens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hartford Conn. Md.

12 MAIDEN NAME OF MOTHER Mary B. Preston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hartford Conn. Md.

14 Informant William H. Buffington (Address) 3609 Sycamore St.

15 Found Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1920.

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1920, to July 11, 1920, that I last saw her alive on July 11, 1920, and that death occurred, on the date stated above, at 6 A. M. The CAUSE OF DEATH* was as follows:

Pneumonia

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1217 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mary's (Hamden)

July 14, 1920

20 UNDERTAKER

ADDRESS

Grace Curgee (son)

3631 Falls Rd.

This should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

JUL 13 1920

D. 44747

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

39

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Albert

(a) RESIDENCE. No. 517 Millington Lane

ST.

WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 51 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1869

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

51

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md;
(State or country)

10 NAME OF FATHER Francis Albert

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Madeline Wissle

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Md.

14 Informant Hospital Records,

(Address)

New City Hospital.

Robert P. Harrison,

15 Filed

JUL 13 1920

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13, 1920

17

I HEREBY CERTIFY, That I attended deceased from
April 3, 1920, to July 13, 1920,
that I last saw him alive on July 12, 1920,
and that death occurred, on the date stated above, at 9:00 A. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Lower Lip

(duration) yrs. 8 mos. ds.

CONTRIBUTORY

(Secondary)

Ornatois

(duration) yrs. 3 mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

J. A. Holden

M. D.

7/13/20 Address) New City Hospital.

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral

July 15 1920

20 UNDERTAKER

ADDRESS

M. J. Fahy & Sons 1827 W. North

0.44748 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.44748

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Med. Gen. Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.

854-37th.

ST.

13

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

George Lewis Apers Jr

(a) RESIDENCE. NO.

(Usual place of abode)

Gayland Gen'l Hosp

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

2 yrs.

8 mos.

24 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 18 1917

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

8

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto City

10 NAME OF FATHER

George L. Shere Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Marie Carrigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Washington

14

Informant (Address)

George L. Shere 854-137-1

JUL 13 1920

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 13 1920

17

I HEREBY CERTIFY, That I attended deceased from *July 12, 7 PM.*, 19 *20*, to *July 13, 4 PM.*, 19 *20*, that I last saw him alive on *July 13*, 19 *20*, and that death occurred, on the date stated above, at *4 A* m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis, Congrenous

(duration) yrs. mos. *5* ds.

CONTRIBUTORY (Secondary)

Peritonitis

(duration) yrs. mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *July 12, 20*

Was there an autopsy? *No*

What test confirmed diagnosis? *operation*

(Signed) *Wm. J. Fox, M. D.*

, 19 *20* (Address) *44 General Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn

July 15 1920

20 UNDERTAKER

ADDRESS

Marion L. Hayes & Sons 1827 W. 7th

Information should be carefully supplied. AGE should be stated EXACTLY. Fact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1749 Ashland Ave. ST.)WARD) 7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Nowell

(a) RESIDENCE. NO.

1749 Ashland Ave. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs.

mos.

ds.

How long in U. S., if of foreign birth? Life yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

George Nowell

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45--

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

general domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Va.

10 NAME OF FATHER

Edwin James

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

14

Informant (Address)

John C. Poole
1749 Ashland Ave.

15

Filed

13 1920

by

Bart P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 12, 1920

17

I HEREBY CERTIFY, That I attended deceased from

May 19, 1920, to July 12, 1920,that I last saw her alive on July 11, 1920,and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted If not at place of death?

Balto. MdDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. Robinson, M. D.Address 5308 Monument St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Charterell RdJuly 13, 1920

20 UNDERTAKER

ADDRESS

Roberts 1495 McEldery

Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. EX. statement of OCCUPATION is very important. See instructions on back of certificates.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

0.44750 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.44750

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 600 4 Springs, ST. 5 WARD) REGISTERED No. C
2-FULL NAME Chris Johnson
(Residence in Baltimore: No. 600 4 Springs, ST. 26 yrs., mos. ds.)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, Col.
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, (Month) (Day) (Year)
7-AGE, 58 yrs., mon., ds.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, House Work
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Md
10-NAME OF FATHER, John Vause
11-BIRTHPLACE OF FATHER, Md
12-MAIDEN NAME OF MOTHER, Mary Webb
13-BIRTHPLACE OF MOTHER, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edgar Brown
(Address) 1504 McElderry St.

15- Robert P. Harrison,
Filed 13 1920, 101
Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 12, 1920
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and pay or inquiry, and that from the evidence obtained, said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy
(Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary)
(Signed) J. H. Smith, M. D.
(Coroner)
101... (Address) E. Jones

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place In the
of death yrs., mos., ds. State yrs., mos., ds.
Where was disease contracted, if not at place of death.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenberg Md
DATE OF BURIAL, July 14, 1920
ADDRESS, 16 Evers 1405 McElderry

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1529 Friendsbury ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. 1529 Friendsbury St.; 5 yrs., 13 mos., 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Jan. 18, 1920
(Month) (Day) (Year)

7-AGE,

5 13 yrs., 13 mos., 13 ds.
If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)None

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Wm. A. Smith, Sr.

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Ethel V. Brown

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. A. Smith, Sr.(Address) 1529 Friendsbury St.

15-

Jul 13 1920 Robert P. Harrison,
191 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 13, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 5, 1920, to July 13, 1920,that I saw him alive on July 12, 1920,and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis(Duration) 7 yrs., 7 mos., 7 ds.

CONTRIBUTORY (Secondary)

(Duration) 7 yrs., 7 mos., 7 ds.(Signed) John D. Harrison M. D.July 13, 1920 (Address) 1529 Friendsbury St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 5 yrs., 13 mos., 13 ds. In the State 5 yrs., 13 mos., 13 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

David Ridge

DATE OF BURIAL,

July 14, 1920

20-UNDERTAKER

William Cook

ADDRESS

5025 North Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

Physicians should state
Exact Statement of OCCUPA-
TION is very important. See instructions on back of certificate.

Spec. 4-9-19 H. P. Co. 1000 Eka.

2.44752 HEALTH DEPARTMENT—CITY OF BALTIMORE 2.44752

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2121 N. Charles ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Robinson

(a) RESIDENCE. No. 2121 N. Charles ST. WARD. (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary W. Robinson

6 DATE OF BIRTH (month, day, and year) Apr 18 1851

7 AGE Years 69. Months 2 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Geo W. Robinson

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Mary E. Buckle

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Mary W. Robinson (Address) 2821 N. Charles St

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-12 1920

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1920, to July 12, 1920, that I last saw him alive on July 11, 1920, and that death occurred, on the date stated above, at 7 a.m. The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus (duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 1919

Was there an autopsy? No

What test confirmed diagnosis? Mars

(Signed) W. H. Pearson M. D.

Address 2105 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Greenmount Cem July 14 1920

20 UNDERTAKER ADDRESS

Wm Coats 502 E. North

JUL 13 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST. 22 WARD) 37

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Parker(a) RESIDENCE. No. 105 W. York St.ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 1894

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)10 NAME OF FATHER John Tab11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)12 MAIDEN NAME OF MOTHER Alice Johnson13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)14 Informant Hospital Records,(Address) New City Hospital15 Filed Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11, 19 20

17

I HEREBY CERTIFY, That I attended deceased from
May 28, 19 20, to July 11, 19 20.that I last saw her alive on July 10, 19 20.and that death occurred, on the date stated above, at 3:00 A. m.

The CAUSE OF DEATH* was as follows:

Syphilitic aortitis(duration) 3 yrs. mos. ds.CONTRIBUTORY
(Secondary)Myocardial infarction(duration) 1 1/2 yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? Date of Was there an autopsy? NoWhat test confirmed diagnosis? Wassermann(Signed) W. Steoman M. D.7/12/20 Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND

20 UNDERTAKER

ADDRESS Commissioner Health,JUL 13 1920

Information should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 13 1920 Burial Permit Clerk.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHOTOCOPIES should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

0.44754 HEALTH DEPARTMENT-CITY OF BALTIMORE 104-091 0.44754
CERTIFICATE OF DEATH

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1446 Reynolds St. 24 WARD)
2-FULL NAME Joseph Sosnowski
(Residence in Baltimore: No. 1446 Reynolds St. yrs. 11 mos. 10 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male	4-COLOR OR RACE White	5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single
6-DATE OF BIRTH August 2, 1919 (Month) (Day) (Year)		
7-AGE yrs. 11 mos. 10 ds. If LESS than 1 day, hrs. or min.?		
8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Infant		
9-BIRTHPLACE (State or country) Baltimore Md		
PARENTS	10-NAME OF FATHER John Sosnowski	
	11-BIRTHPLACE OF FATHER (State or country) Poland	
	12-MAIDEN NAME OF MOTHER Theresa Wallace	
	13-BIRTHPLACE OF MOTHER (State or country) Poland	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Sosnowski
(Address) 1446 Reynolds

15- Robert P. Harrison,
Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH
July 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 8th, 1920, to July 12, 1920, that I saw him alive on July 11, 1920, and that death occurred, on the date stated above, at 1:15 P. M.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(Duration) yrs. 1 mos. 1 ds.
Contributory (SECONDARY) Med Coarctis
(Duration) yrs. 4 mos. 4 ds.
(Signed) Thos A Stevens M. D.
July 12, 1920 (Address) 2866 Reaford Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL
Holy Cross A.A. Co.
DATE OF BURIAL
7/14/1920
20-UNDERTAKER
J. Frew M. Conly
ADDRESS
130 E. Fortian

JUL 13 1920

D.44755 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2722 Hampden

ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elsie Viola Garity

(a) RESIDENCE. NO. 2722 Hampden

ST.: 12 WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

2 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 19 - 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

James T. Garity

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Clara L. Lowell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Hanna L. Lowell 2722 Hampden St

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 12 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 9 1920, to July 12 1920

that I last saw her alive on July 12 1920

and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Coronary

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

R. P. Harrison, M.D.

(Address)

117 U. S. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery

July 14 1920

20 UNDERTAKER

ADDRESS

Robt J. Turner, Jr.

1442 N. Broadway

Information should be carefully supplied. AGE should be stated EXACTLY. Place of death should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 13 1920

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

10.44756 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.44756

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *St. Michael's Roman Catholic Church*
CITY OF BALTIMORE (No. *3*) ST. *3* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Johan Christian Aachmann*
(Residence in Baltimore: No. *114 Broadway (South)* St.; yrs., mos. *14* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *married* (Write the word.)
6-DATE OF BIRTH, *About ? 1865*
(Month) (Day) (Year)

7-AGE, *abt 55 ? ?* If LESS than 1 day, *undisputed*
yrs. mos. ds.hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Interior Decorator*
(b) General nature of industry, business, or establishment in which employed (or employer), *Rambush Security Co.*

9-BIRTHPLACE, (State or Country), *Denmark*

10-NAME OF FATHER, *not known*
11-BIRTHPLACE OF FATHER (State or Country), *not known*
12-MAIDEN NAME OF MOTHER, *not known*
13-BIRTHPLACE OF MOTHER (State or Country), *not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Mr Geo. H. Ludwig (son-in-law)*
(Address) *449-68 St-Brooklyn N.Y.*

15-
JUL 13 1920 Robert P. Harrison,
Filed, 101, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 12*, 19*20*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *investigation* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-
topsy for inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally crushed by fall from scaffold
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Sheeny T. J. Fisher* D.
July 13 1920 (Address) *106 Balto St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, *0* yrs. *0* mos. *14* ds. In the *0* yrs. *0* mos. *14* ds.

Where was disease contracted, if not at place of death?

St. Michael's Roman Catholic Church
Former or usual residence *Brooklyn N. Y.*

19-PLACE OF BURIAL OR REMOVAL, *Brooklyn N. Y.* DATE OF BURIAL, *July 14, 1920*

20-UNDERTAKER, *Stewart M. Brown Co. (W. H. Wood)* ADDRESS *108 W. North Ave*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

0.44757 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.44757

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *Franklin St Hospital* St. *19* WARD)
2-FULL NAME *Mallissa Yarborough*
(Residence in Baltimore: No. *508 4 Bruce* St.; yrs., mos. *6* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female*
4-COLOR OR RACE. *Colored*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
6-DATE OF BIRTH. *Unknown*, 1.....
(Month) (Day) (Year)
7-AGE. *42* yrs. mos. ds.
If LESS than 1 day, hrs. or min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Domestic*
(b) General nature of industry, business, or establishment, in which employed (or employer). *Private Family*
9-BIRTHPLACE, (State or Country). *Virginia*
10-NAME OF FATHER. *George Stamps*
11-BIRTHPLACE OF FATHER (State or Country). *Virginia*
12-MAIDEN NAME OF MOTHER. *Nancy Cobb*
13-BIRTHPLACE OF MOTHER (State or Country). *Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). *Nancy Stamps*
(Address). *Quincy U. C.*

15-

Robert P. Harrison,
Burial Permit Clerk Registrar.
JUL 13 1920

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 11*, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*
(Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was *as follows:*
Carbolic Acid Poisoning
Self administered
suicide
(Duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *James H. Austin* M. D.
(Coroner.)

July 12, 1920 (Address) *207 E. Chase St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place *Franklin St. Hos.* In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

508 4 Bruce St.
Former or usual residence *New Port News Va.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Ourshan W. C. *July 14* 1920

20-UNDERTAKER ADDRESS *142*

John W. Toadert *W. Hill St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

10.44758 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.44758

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 175-001)

2-FULL NAME

(Residence in Baltimore: No. 612 S. Ann.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, Married, Widowed, or Divorced, (Write the word.) Bay

6-DATE OF BIRTH,

7-AGE, 5 yrs., 8 mos., 17 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balt.

10-NAME OF FATHER, Felix Sienkiewicz

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Sofia Pakula

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Felix Sienkiewicz

(Address), 612 S. Ann. St.

15-

Robert P. Harrison,

101

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 12, 1920

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed), J. M. S. D.

7-13, 1920

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, ... yrs., ... mos., ... ds. In the State, ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

D. 44759 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 S. Fulton Ave. ST.; 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Delker

(a) RESIDENCE. No. 523 S. Fulton Ave.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William E. Delker

6 DATE OF BIRTH (month, day, and year) Jan. 24, 1881.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ohio.
(State or country)

10 NAME OF FATHER Henry Micheals

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Kalter

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.14 Informant Catherine E. Delker
(Address) 620 S. Fulton Ave.

15 Filed 13 1920 Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1919, to July 11, 1920, that I last saw her alive on July 11, 1920, and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy
Bright's Disease & Tuberculosis

CONTRIBUTORY (duration) yrs. mos. ds.
(Secondary) Bright's Disease & Tuberculosis
of lungs (duration) 1 yrs. 2 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Kernan, M. D.

7-12, 1920 Address) 708 E. Union St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park Cemetery,

7/14/20

20 UNDERTAKER

Joseph B. Cook

ADDRESS
1003 W. Baltimore
Street

Physicians should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 13 1920

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044761 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044761

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 13)

2-FULL NAME

(Residence in Baltimore: No. 2310 Callow me

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUL 14 1920

BOTTE I ELAUTRA

BALTIMORE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER STEWART & MOWEN COMPANY

ADDRESS

108 W. NORTH AVE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #1735 Park Ave. ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elizabeth Lindsay.

(a) RESIDENCE, NO.

#1735 Park Ave.

ST.

WARD.

(Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 5 mos. 23 ds. How long in U. S., if of foreign birth? 69 yrs. 5 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	WHITE	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

(Single)

6 DATE OF BIRTH (month, day, and year) January-19-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None.

(b) General nature of industry, business, or establishment in which employed (or employer)

None.

(c) Name of employer

None.

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

Maryland

10 NAME OF FATHER George W. Lindsay11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore
Maryland.12 MAIDEN NAME OF MOTHER Elizabeth Auld13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore
Maryland.14 Informant Thos. J. Lindsay (brother)
(Address) 2309 Maryland Av.15 JUL 14 1920 ROBERT B. KEAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 192017 I HEREBY CERTIFY, That I attended deceased from
Jan. 10, 1920, to July 11, 1920,
that I last saw her alive on July 11, 1920,
and that death occurred, on the date stated above, at 430 A. m.

The CAUSE OF DEATH* was as follows:

Uterine Fibroma

(duration) Some yrs. mos. ds.
General anasarca
CONTRIBUTORY Anemia & ex haemorrh
(Secondary) (duration) 6 yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert W. Mufflin M. D., 19 (Address) 1016 Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park Cemetery

DATE OF BURIAL

July-14 1920

20 UNDERTAKER

STEWART & MOWEN COMPANY

ADDRESS

108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH CARE. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044763 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044763

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. Johns Hopkins Hospital ST. 9767 WARD)
2-FULL NAME Gladys A. Lausen
(Residence in Baltimore: No. 1530 Homestead St.; yrs., 6 mos. -- ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
4-COLOR OR RACE. White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
6-DATE OF BIRTH, April 12, 1917
7-AGE, 3 yrs., 3 mos., -- ds. If LESS than 1 day, ... hrs. or ... min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), New Jersey
10-NAME OF FATHER, William C. Lausen
11-BIRTHPLACE OF FATHER (State or Country), New Jersey
12-MAIDEN NAME OF MOTHER Gladys M. McClure
13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Gladys M. Lausen (Mother)
(Address) 1530 Homestead St.

15- JUL 14 1920
Filed. 191. ROBERT B. KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH July 12 1920, 191...
17-I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Burns. As fireman
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(Signed) J. B. Smith, M. D.
(Coroner)
1738 (Address) 48 West

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...
Former or usual residence New Jersey

19-PLACE OF BURIAL OR REMOVAL. NEW CATHEDRAL. DATE OF BURIAL. JUL 15 1920

20-UNDERTAKER. JOHN F. DENNY ADDRESS 716 LIGHT ST.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 N. Milton ST.; 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 21 N. Milton Ave St.; 29 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah C. Bruff
(Address) 21 N. Milton Ave

15-

JUL 14 1920

ROBERT A. BRAUTER

BRIAL FAMIL

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 10, 1920, to July 13, 1920, that I saw her alive on July 12, 1920, and that death occurred, on the date stated above, at 8:30 a.m. The CAUSE OF DEATH* was as follows:Acute Gastritis

CONTRIBUTORY (Secondary)

(Signed) Isthy C. Healey M. D.
13, 1920 (Address) 2600 E. 18th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

St. Michaels July 17, 1920

20-UNDERTAKER

ADDRESS

John Mitchell 1814 Bayette St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE is CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1631 Aliceanna ST.; 2 WARD)

2-FULL NAME

(a) RESIDENCE. No. 1631 Aliceanna ST., 2 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 17 yrs. 0 mos. 0 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19-19097 AGE Years 11 Months 0 Days 24 If LESS than 1 day, 0 hrs. 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. (State or country)10 NAME OF FATHER Vicent Bartosiewicz11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)12 MAIDEN NAME OF MOTHER Julia Majewski13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)14 Informant Julia Bartosiewicz (Address) 1631 Aliceanna St.

JUL 14 1920 ROBERT E. LAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 19 2017 I HEREBY CERTIFY, That I attended deceased from June 20, 19 20, to July 13, 19 20, that I last saw him alive on July 13, 19 20, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH was as follows:

Gentle febrile - gentle
rheumatic fever -
acute Endocarditis(duration) 2 yrs. 0 mos. 0 ds.CONTRIBUTORY Acute Cardiac Dilatation (Secondary)(duration) 1 yrs. 0 mos. 0 ds.18 Where was disease contracted if not at place of death? unknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Findings(Signed) 77rd Ruzick M. D.18, 1920 Address 808 N. Patterson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL July 15 19 202 UNDERTAKER Mr. G. alkowski ADDRESS 1618 Eastern Ave.

Physician should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Virginia Tucker*

(a) RESIDENCE. No. *225 S. High St.* ST., *Unknown* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year) *Feb 23-1916*

7 AGE *4* Years *4* Months *19* Days

If LESS than 1 day,.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, Profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Pennsylvania* (State or country)

10 NAME OF FATHER *Geo. Tucker*

11 BIRTHPLACE OF FATHER (city or town) *Russia* (State or country)

12 MAIDEN NAME OF MOTHER *Catherine Ritz*

13 BIRTHPLACE OF MOTHER (city or town) *Pennsylvania* (State or country)

14 Informant *Hospital Record* (Address) *J. H. H.*

15 JUL 14 1920

ROBERT E. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 12 1920*

17

I HEREBY CERTIFY, That I attended deceased from

July 8 1920, to *July 12 1920*,

that I last saw her alive on *July 12 1920*,

and that death occurred, on the date stated above, at *7:30 p.m.*

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery

(duration)yrs.mos. *4* ds.

CONTRIBUTORY (Secondary)

(duration)yrs.mos.ds.

18 Where was disease contracted if not at place of death? *home*

Did an operation precede death? *No* Date of.....

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Stool cultures*

(Signed) *Harold L. Higgins*, M. D.

7/3/20 (Address) *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Vincent

7/14/20

20 UNDERTAKER

ADDRESS

M. W. C. Lippel

37 S. Cal St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044767

HEALTH DEPARTMENT—CITY OF BALTIMORE

64-1044767

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 3921 Canterbury Road
CITY OF BALTIMORE (No. Nolandy Park ST. 14 WARD)
2-FULL NAME Thomas Wheeler Jenkins
(Residence in Baltimore: No. 1521 Bolton St. St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)
6-DATE OF BIRTH. November 10, 1894
(Month) (Day) (Year)
7-AGE. 25 yrs. 8 mos. 2 ds. If LESS than 1 day, ... hrs. or ... min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Clark
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE. (State or Country) Baltimore, Md.
10-NAME OF FATHER. Thomas W. Jenkins Jr.
11-BIRTHPLACE OF FATHER (State or Country). Baltimore, Md.
12-MAIDEN NAME OF MOTHER. Lina M. Walker
13-BIRTHPLACE OF MOTHER (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) David W. Jenkins
(Address) McCallister & Orchard Sts.

15- JUL 14 1920
Filed..... 191. ROBERT K. TRAUTER
BRIAN PERMIT OFFICE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 12, 1920
(Month) (Day) (Year)
17- I HEREBY CERTIFY, THAT I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Chorea
(Duration)..... yrs..... mos..... ds.
CONTRIBUTORY.....
(Secondary).....
(Duration)..... yrs..... mos..... ds.
(Signed) John H. Harrison, D. (Coroner).
July 13 1920 (Address) 3632 Rolan Rd.
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. New Cathedral DATE OF BURIAL, July 15 1920
20-UNDERTAKER. Henry W. Jenkins & Son ADDRESS McCallister & Orchard Sts.

N. B.—WRITE PLAINLY, WITH CARE.—THIS IS A PRELIMINARY STATEMENT. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1044768

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044768

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Church Home and Infirmary*
CITY OF BALTIMORE: (No. *711 Broadway + Fairmount* ST. *27* WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary Ellen Vogler*
(a) RESIDENCE. NO. *Harford Road + Gibbons Ave.,* ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred *41* yrs. *3* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *wh* 5 Single, Married, Widowed, or Divorced (write the word) *married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *George C. E. Vogler*

6 DATE OF BIRTH (month, day, and year) *July 12th 1867*
7 AGE Years *52* Months *11* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work *house wife*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Meadville Pa*

10 NAME OF FATHER *Conrad Wegelark*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*

12 MAIDEN NAME OF MOTHER *Mary E. McArthur*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Meadville Pa*

14 Informant *A. Wegelark*
(Address) *2031 E. W. St.*

15 JUL 14 1920 ROBERT E. KAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 12, 1920*

17 I HEREBY CERTIFY, That I attended deceased from *July 5, 1920, to July 12, 1920,*
that I last saw her alive on *July 12, 1920,*
and that death occurred, on the date stated above, at *4:27 P.M.*

The CAUSE OF DEATH* was as follows:
Appendicoid Abscess with Gangrene of Head of Cecum.
(duration) yrs. mos. *13* ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*

Did an operation precede death? *Yes* Date of *July 6, 1920.*

Was there an autopsy? *No*

What test confirmed diagnosis? *operation*
(Signed) *Walter T. Anderson* M. D.

July 12, 1920 (Address) *Church Home and Infirmary.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL
Druid Ridge Cemetery *July 15th 1920*

20 UNDERTAKER ADDRESS
George Schilling & Sons *1126 Monument St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *306 South Mount* ST.; *19* WARD)

2-FULL NAME

(Residence in Baltimore: No. *306 South Mount* St.; *1* yrs., *+* mos., *+* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female White

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH

May 1st 1861
(Month) (Day) (Year)

7-AGE

59 2 12
yrs. mos. ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Wife, alone. Colligative Nephrosis*9-BIRTHPLACE,
(State or Country).*Ohio*

10-NAME OF FATHER

John Schubert

11-BIRTHPLACE OF FATHER

(State or Country).

Austria

12-MAIDEN NAME OF MOTHER

Helen G. Smith

13-BIRTHPLACE OF MOTHER

(State or Country).

Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *D. H. Hoffman*(Address) *2100 North Ave.*

15

JUL 14 1920

ROBERT A. ERAUTER

Filed..... 191. Burial Permit. Class. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 13th 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

*July 11th 1920, to July 13th 1920,*that I saw her alive on *July 13th 1920,*and that death occurred, on the date stated above, at *9¹⁵ a.m.*

The CAUSE OF DEATH* was as follows:

*Colligative Nephrosis**Had been in hospital from**gastro-intestinal trouble 6 or 7 years*CONTRIBUTORY (Secondary) *Had been in hospital from**gastro-intestinal trouble 6 or 7 years*(Signed) *D. H. Hoffman* M. D.*7/14th 1920* (Address) *2100 North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Ohio

19-PLACE OF BURIAL OR REMOVAL.

Western Cerr.

DATE OF BURIAL.

July 14th 1920.

20-UNDERTAKER

Harry H. Witzke

ADDRESS

1531 W. Lombard St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044771

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044771

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.: *1* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Gus Trenoulis*(a) RESIDENCE. NO. *Liberty Hall*

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *8* yrs.

mos.

ds.

How long in U. S., if of foreign birth? *8* yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M.*4 COLOR OR RACE *White*5 Single, Married, Widowed,
or Divorced (write the word) *Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *1896.*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work *Laborer*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) *Greece*10 NAME OF FATHER *Sten Trenoulis*11 BIRTHPLACE OF FATHER (city or town)
(State or country) *Greece*12 MAIDEN NAME OF MOTHER *Elynda Abramson*13 BIRTHPLACE OF MOTHER (city or town)
(State or country) *Greece*

14

Informant
(Address) *John Trenoulis*
Martin's Ferry Ohio

15

JUL 14 1920

ROBERT B. KAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 13* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

*4/20, 20, to 7/7, 20,*that I last saw him alive on *7/7, 20,*and that death occurred, on the date stated above, at *7:45 p.m.*

The CAUSE OF DEATH* was as follows:

*Generalized Tuberculosis*CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *No.* Date of *3/15/20*Was there an autopsy? *No.*What test confirmed diagnosis? *Chest X-ray.*(Signed) *W. H. Stein* M. D.7/17/20 (Address) *University Hospital**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Martin's Ferry Ohio *7/14/20*

20 UNDERTAKER

James & Joulson *147 Green St*

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1044772

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044772

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mrs. Ross*)ST. *4*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *Bilton S.R.*

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND, of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7/1/20

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

JUL 14 1920

ROBERT H. KRAUTER

Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*7/13*19*20*

17

I HEREBY CERTIFY, That I attended deceased from

7/12, 19*20*, to *7/13*, 19*20*.that I last saw him alive on *7/13*, 19*20*.and that death occurred, on the date stated above, at *2 p.* m.

The CAUSE OF DEATH* was as follows:

*Premature Birth
Active 6 or 7 mon.*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *Yes* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Lucas Q. R. D. D.* M. D.19 (Address) *Mrs. Ross*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt. Auburn Cem.**7/14/20*

20 UNDERTAKER

ADDRESS

J. Thoms & Co. 1611 Madison St.

N. B.—WHILE FILLING OUT THIS CERTIFICATE, PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST.: *4* WARD)2-FULL NAME *Baby Dan No. II,*(a) RESIDENCE. NO. *Dillon, S. C.* ST. _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

*W.*5 Single, Married, Widowed,
or Divorced (write the word)*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 12-1920

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.
43

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*home*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Mercy Hospital
Baltimore*

10 NAME OF FATHER

*David H. Faas*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Austria*

12 MAIDEN NAME OF MOTHER

*Kittie Copland*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Lancaster
Pa.*

14

Informant
(Address)*David Faas
Dillon St.*

15

Filed

*JUL 14 1920*ROBERT S. LEAUTER
RegistrarBurial Permit *Given*

REGISTERED NO. _____

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 12 1920*

17

I HEREBY CERTIFY, That I attended deceased from

7/12 1920, to *7/12 1920*,
that I last saw him alive on *7/12 1920*,and that death occurred, on the date stated above, at *4.45 P. m.*

The CAUSE OF DEATH* was as follows:

*Preparture Child -
before 6 + 1 mos.*

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date of _____Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Samuel B. Smith*, M. D.19, 1920 (Address) *Mary 1000**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Balto Hebrew Cem**7/14/20*

20 UNDERTAKER

ADDRESS

J. Ahrens & Co 1611 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

4044774

HEALTH DEPARTMENT—CITY OF BALTIMORE

44774

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hosp.*ST.: *4*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE, No. *Dillon St. C.*

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, 5 hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

JUL 14 1920

ROBERT S. LAUTER Registrar

Burial Permit Check

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1920

17

I HEREBY CERTIFY, That I attended deceased from

7/12, 1920, to 7/13, 1920,

that I last saw him alive on 7/13, 1920,

and that death occurred, on the date stated above, at 20 m.

The CAUSE OF DEATH* was as follows:

Pneumonia with
Scurvy 6 & 7 mos.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *John D. Ridge* M. D.Yr. 1920 (Address) *Mercy Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

John D. Ridge & Co 1611 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 St. Washington WARD)

2-FULL NAME Andery E. Williams

(a) RESIDENCE. NO. 1502 N. Washington ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female COLOR OF RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles

6 DATE OF BIRTH (month, day, and year) Dec 4 - 1899

7 AGE Years 7 Months 10 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Charles H. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elizabeth M. Newman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Charles H. Williams (Address) 1502 N. Washington

15 Filled ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1920

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1920, to July 14, 1920, that I last saw her alive on July 11, 1920, and that death occurred, on the date stated above, at 2:00 m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) B. P. Henry, M.D.

July 14, 1920 (Address) 1305 N. Patterson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

JUL 14 1920

McCook

502 E. North

LTIMORE
91-08 44776
REGISTERED NO.
(If death occurs
a hospital or in-
stitution, give its N
instead of street

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST.: 2 WARD)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Lib^{rs} mos

ds. How long in U. S., if of foreign birth?

yrs. mos. ds

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1920

I HEREBY CERTIFY, That I attended deceased from

July 2, 1920 to July 13, 1920.

that I last saw h im alive on July 13, 19 20

and that death occurred, on the date stated above, at 10:30 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis

Number of children	Frequency
0	1
1	4
2	6
3	4
4	2
5	1
6	1
7	1
8	1
9	1
10	1

.....(duration) yrs. 1 mo. ds

CONTRIBUTORY Broncho-pneumonia
(Secondary)

.....(duration)yrs.mos. 5 ds.

18 Where was disease contracted
if not at place of death? _____

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) V. H. Egan, M. D.

/13/9 20 address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

*State the Disease Causing Death, or in deaths from Violent Causes.

state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

[illegible]

19 PLACE OF BURIAL, CREMATION OR REMOVAL		DATE OF BURIAL

La. L. Park April 11

(Address) New City Hospital

15 JUL 14 1920 ROBERT E. KAUTER

906141920 Bahia Brazil Registrar

20 UNDERTAKER	ADDRESS
----------------------	----------------

William Cool 582 E. North

ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1030 E. North Ave ST.: 9 WARD)

2-FULL NAME

E. Grant Whitaker

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

1030 E. North Ave ST.

WARD:

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofBessie M. Whitaker

6 DATE OF BIRTH (month, day, and year)

June 7-1869

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.511

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workFish Dealer(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore Md.

10 NAME OF FATHER

Dorsey Whitaker11 BIRTHPLACE OF FATHER (city or town)
(State or country)Harford Co Md

12 MAIDEN NAME OF MOTHER

May E. Gill13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Baltimore Md

14

Informant
(Address)Bessie M. Whitaker
1030 E. North Ave

15

Filed

19

ROBERT E. KRAUTH

Registrar

JUL 14 1920BRIAL PERMITLilly - Homewood Ave & North Ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 12-1920

17

I HEREBY CERTIFY, That I attended deceased from

May 1st, 1920, to July 12th, 1920.that I last saw him alive on July 12th, 1920.and that death occurred, on the date stated above, at 6:10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(duration) yrs. 2 mos. 12 ds.CONTRIBUTORY
(Secondary)(duration) yrs. 7 mos. 7 ds.

18 Where was disease contracted

If not at place of death? at place of deathDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? urinalysis(Signed) P. E. Gill, M. D.July 1920 address) for S. HuntState the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London ParkJuly 15-1920

20 UNDERTAKER

William Cook

ADDRESS

502 E. NorthAve

Physicians should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH CAPS AND INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

1044778 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044778

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. II2I So. Binney

ST. I WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME WLADISLAW RAKOWICZ,

(Residence in Baltimore: No. II2I So. Binney

18. St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male, 4-COLOR OR RACE, White 5-SINGLE, MARRIED, Married, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Day laborer, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country), Poland,

10-NAME OF FATHER, Joseph Rakowicz,

11-BIRTHPLACE OF FATHER (State or Country), Poland,

12-MAIDEN NAME OF MOTHER Jozefa Drzasdzynska,

13-BIRTHPLACE OF MOTHER (State or Country), Poland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johanna Rakowicz, (Wife)

(Address) # II2I So. Binney Street

15-

Filed JUL 14 1920 191. ROBERT B. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 13, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Henry J. ... M. D. (Coroner) July 13, 1920 (Address) 1610 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus, DATE OF BURIAL, July 15, 1920.

20-UNDERTAKER, M. F. Sadowski, ADDRESS, 705 S. Ann. St.

1044779 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2203 Eastern Ave ST.: 1 WARD)

2-FULL NAME

Miss Anna Szymanski

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 2203 Eastern Ave. ST.: 1 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE White	5 Single, Married, Widowed, or Divorced (write the word) Single
-----------------	--------------------------	--

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14-1891

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
29 yrs 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Factory

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

10 NAME OF FATHER Joseph Szymanski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Agnes Merowska

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)14 Informant Dr. Amelia E. Link
(Address) 1717 N. Caroline St.15 Filed JUL 14 1920 ROBERT E. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14th 192017 I HEREBY CERTIFY, That I attended deceased from April 15, 1920, to July 13th, 1920, that I last saw her alive on July 13th, 1920, and that death occurred, on the date stated above, at 5:45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY Exhaustion
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? The pulmonary signs

(Signed) Amelia E. Link M. D.

, 19 (Address) 1717 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Stanislaus July 17th 1920

20 UNDERTAKER ADDRESS

M. F. Sedowski 708 S. Union

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

1244780

HEALTH DEPARTMENT—CITY OF BALTIMORE

1244780

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1707 Latrobe St. 12 WARD)
2-FULL NAME Gertrude Thurman
(Residence in Baltimore: No. 1707 Latrobe St. 3 yrs. 3 mos. ds.)
REGISTERED No. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female	4-COLOR OR RACE Cauc	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married
6-DATE OF BIRTH,, 1..... (Month) (Day) (Year)		
7-AGE, 33 yrs. 3 mos. 3 ds. If LESS than 1 day,hrs. or....min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work..... House work (b) General nature of industry, business, or establishment in which employed (or employer)..... House work		
9-BIRTHPLACE, (State or Country), Alabama		
PARENTS.	10-NAME OF FATHER, John Reese	
	11-BIRTHPLACE OF FATHER (State or Country), Alabama	
	12-MAIDEN NAME OF MOTHER Daisy Harris	
	13-BIRTHPLACE OF MOTHER (State or Country), Alabama	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Daisy Reese
(Address) 1707 Latrobe

15- JUL 14 1920 ROBERT E. KRAUTER
Filed..... 101.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 14, 1920
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Cauda & Cor Pulmonale
Prob. val. of heart.
4 days (Duration)..... yrs..... mos..... ds.
CONTRIBUTORY.....
(Secondary).....
(Duration)..... yrs..... mos..... ds.
(Signed) W. Staley M. D.
(Coroner.)
July 13, 1920 (Address) 1639 Bury

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,
Mt. Auburn July 15, 1920

20-UNDERTAKER
Mrs R. A. Elliott
ADDRESS 125-
Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-2-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST.: *6* WARD)

2-FULL NAME

James O'Donnell

(a) RESIDENCE. NO. *1907 E Fayette St.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Child*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Child*

6 DATE OF BIRTH (month, day, and year) *Oct 5 1919*

7 AGE Years *9* Months *8* Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md* (State or country)

10 NAME OF FATHER *Lawrence O'Donnell*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore Md* (State or country)

12 MAIDEN NAME OF MOTHER *Carita Harrigan*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore Md* (State or country)

14 Informant *Hospital Record* (Address) *J. H. H.*

15 Filed *Jul 14 1920* *ROBERT E. LAUTER*

Bureau Form 10-20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 13 1920*

17 I HEREBY CERTIFY, That I attended deceased from *July 5*, 19*20*, to *July 13*, 19*20*, that I last saw him alive on *July 13*, 19*20*, and that death occurred, on the date stated above, at *4:20 a. m.*

The CAUSE OF DEATH* was as follows:

Diarrhea

(duration) yrs. mos. ds. *10*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Harold L. Higgins, M. D.*

7/13, 1920 Address *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cem

July 15 1920

20 UNDERTAKER

ADDRESS

Ans C. Miller

2334 Jefferson St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

body at city morgue Mitchell Williamson
1044782 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044782

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Mt. Police Station*)

ST.: *4*

WARD

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mitchell Williamson*

(Residence in Baltimore: No. *611 W. Saratoga St.*)

St. *3* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Color

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

born know

(Month) (Day) (Year)

7-AGE,

about 40 yrs.

IF LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Rubber

9-BIRTHPLACE,

(State or Country),

born know

10-NAME OF FATHER,

Went Kwan

11-BIRTHPLACE OF FATHER

(State or Country),

Kent, Kwan

12-MAIDEN NAME OF MOTHER

Kwan Kwan

13-BIRTHPLACE OF MOTHER

(State or Country),

Kwan Kwan

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Daniel Easton*

(Address) *916 P. Ave.*

15-

FUL 14 1920

101. *ROBERT B. KRAUTH*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

4

1920

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said (Inquest, or autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Sclerotic disease of the heart

(Duration) *born know* yrs. mos. ds.

CONTRIBUTORY (Secondary) *born know*

(Duration) yrs. mos. ds.

(Signed) *H. G. G. G.* M. D. (Coroner)

7-12-1912 Address *117 W. Saratoga St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Wilmington N.C.

July 14 1920

20-UNDERTAKER

ADDRESS

Daniel Easton

916 P. Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

1044783 *Herbert Woodford* HEALTH DEPARTMENT—CITY OF BALTIMORE 182 1044783

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Lyman Hospital*
CITY OF BALTIMORE (No. *12* ST. *12* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Herbert Woodford*
(Residence in Baltimore: No. *2468 Buckhanna* St.; (yrs., *33*) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *Col.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*
6-DATE OF BIRTH, *1885*
(Month) (Day) (Year)

7-AGE *35* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Police*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *va*

PARENTS.
10-NAME OF FATHER, *Robert Woodford*
11-BIRTHPLACE OF FATHER (State or Country), *va*
12-MAIDEN NAME OF MOTHER, *Willie Boul*
13-BIRTHPLACE OF MOTHER (State or Country), *va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Mary Woodford*
(Address) *310 West Mt. Pike*

15- *14 1920* 191- *Robert E. Krauth* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 12, 1920*
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held in (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:
Homicide by Pistol Shot
CONTRIBUTORY (Secondary) *None*
(Signed) *Max Buckley* (Coroner.)
718 R. 1st St. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL, *July 15, 1920*
Metcalburn Cemetery
20-UNDERTAKER ADDRESS
Chas. G. Bailey 1421 Jefferson St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1044784 HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH.

REGISTERED NO. 1044784

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 S. Stricker St. ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Ida Browning

(a) RESIDENCE. No. 113 S. Stricker St. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married
5a If married, widowed, or divorced
HUSBAND or (or) WIFE of Luther L. Browning
6 DATE OF BIRTH (month, day, and year) Feb. 4, 1867.
7 AGE Years Months Days If LESS than 1 day, hrs. or min.
53 5 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife- At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.
(State or country) Md.

10 NAME OF FATHER Joshua N. Barton
11 BIRTHPLACE OF FATHER (city or town) Balto. Co.
(State or country) Maryland
12 MAIDEN NAME OF MOTHER Mary K. German
13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Maryland

14 Informant Luther L. Browning
(Address) 113 S. Stricker St.

15 Filed JUL 14 1920 ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1920

17 I HEREBY CERTIFY, That I attended deceased from 1915 to July 11, 1920, that I last saw h. alive on July 11, 1920, and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:

Paresis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? George R. R. R.

(Signed) Thos. B. Cook, M. D.

, 19 (Address) P. R. R.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Loudon Park Cemetery.

7/14/20

20 UNDERTAKER

Joseph L. B. Cook

ADDRESS 1603 N. B. St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item in this section should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1044785

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044785

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University of Maryland Hospital* ST. *19* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

James T. Conley

(a) RESIDENCE. No. *349 S. Stricker* ST. *19* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Sarah C. Conley

6 DATE OF BIRTH (month, day, and year)

March 4 1891

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

79

4

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired - Asst Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

Tin Shop

(c) Name of employer

Bush & Co.

9 BIRTHPLACE (city or town) (State or country)

Maryland Baltimore

10 NAME OF FATHER

Conley

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

U.S.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14 Informant (Address)

Sarah C. Conley 349 S. Stricker St

15

JUL 14 1920 *ROBERT B. KRAUTER*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

7/14 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 16 1920, to July 14 1920

that I last saw him alive on *July 13 1920*

and that death occurred, on the date stated above, at *730 a.m.*

The CAUSE OF DEATH* was as follows

Myocardial Prostate (simple)

CONTRIBUTORY (Secondary)

(duration) *2* yrs. *7* mos. *7* ds.

Myocardial Insufficiency

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *6/19/20*

Was there an autopsy? *no*

What test confirmed diagnosis?

Urinal & Biopsy

(Signed)

John H. H. H.

M. D.

7/14/20

(Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cem

July 17 1920

20 UNDERTAKER

Joseph B. Cook

1003 W. Baltimore Street

BURIAL PERMIT

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 S. Caroline St ST.; 3 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Residence in Baltimore: No. 422 S. Caroline St St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
Single

6-DATE OF BIRTH,

..... May 31 , 1920
(Month) (Day) (Year)

7-AGE,

..... 1 13
yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),Baltimore10-NAME OF
FATHER,Bartholoma Cardora11-BIRTHPLACE
OF FATHER
(State or Country),Italy12-MAIDEN NAME
OF MOTHERVentura Lombardi13-BIRTHPLACE
OF MOTHER
(State or Country),Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....Bartholoma Cardora.....(Address).....422 S. Caroline St.....

15-

Robert P. Harrison,..... 14 1920
Registral.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

..... July 14 , 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 31 1920, to July 14 1920,that I saw him alive on July 14 1920,and that death occurred, on the date stated above, at 8.4 m.

The CAUSE OF DEATH* was as follows:

Premature Birth - congenital
weakness to thrive

(Duration)..... yrs. mos. ds.

CONTRIBUTORY
(Secondary)Infantile colic

(Duration)..... yrs. mos. ds.

(Signed).....

Joseph J. Venturi M. D.July 14, 1920. (Address).....14 S. Caroline St.....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Vincent's Cem. July , 1920.

20-UNDERTAKER

ADDRESS

Wendell W. Zippel & Son
14 S. Caroline St.....

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. ~~PHYSICIANS~~ should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ~~OCCUPATION~~ is very important. See instructions on back of certificate.

✓ 10.44787

184

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., moe. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>male</i>	4-COLOR OR RACE, <i>white</i>	5-SINGLE, <i>single</i> MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
6-DATE OF BIRTH, , <i>1</i> (Month) (Day) (Year)		
7-AGE, <i>1 1/2 hours ?</i> yrs. mos. ds. If LESS than 1 day, hrs. or min. ?		

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... *none*

(b) General nature of industry, business, or establishment in which employed (or employer)..... *ad*

D-BIRTHPLACE.
(State or Country).

PARENTS.	10-NAME OF FATHER,
	11-BIRTHPLACE OF FATHER (State or Country).
	12-MAIDEN NAME OF MOTHER
	13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....
(Address).....

16-
14 1920
FILED
1920
101
REGISTRAR.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 22, 1940
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the
remains described above, held an..... *Inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, au-)

See page 7 and that said deceased came to *his* death
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Asplen 19 (found in water, with ^{much} strong green
J. Green house & d
(Duration) . . . yrs. . . . mos. . . . da

CONTRIBUTORY.....
(Secondary).....
..... (Duration)..... yrs..... mos..... ds.
(Signed) *W. T. Rely*..... M. D.
(Coroner.).....
..... 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place Leavenworth In the
of death....yrs.....mos.....ds. State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

10-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL.

20-UNDERTAKER

DATE OF BURIAL.

JUL 1 1920

NEVER WRITE IN UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Fact stated on back of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 lks.

2044788

HEALTH DEPARTMENT—CITY OF BALTIMORE

2044788

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *637 W. Saratoga St.* ST. *11* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

Colored

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 9-1886*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

34

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Long Shot Gunner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Georgia*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) *2*

12 MAIDEN NAME OF MOTHER *2*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *2*

14

Informant (Address) *J. H. H. Records*

15

Filed

19 Robert P. Harrison,

Registrar

JUL 14 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 9* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from

July 6, 19*20*, to *July 9*, 19*20*,

that I last saw him alive on *July 9*, 19*20*,

and that death occurred, on the date stated above, at *6:40 a.m.*

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *J. Schumacher*, M. D.

, 19*20* (Address) *The Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

JUL 14 1920

WHEN FILING, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERYTHING SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. See instructions on back of certificates.

Spec. — 6-2-19 — H. P. Co. — 1003 Bka.

0.44789 *John T. Leitch* HEALTH DEPARTMENT—CITY OF BALTIMORE *10,44789*

CERTIFICATE OF DEATH.

9-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Jack Leitch*

(a) RESIDENCE, NO. *29 N. Carey*

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *3* yrs. *1* mos. *6* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 7-1917*

7 AGE Years *3* Months *1* Days *6* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER *Percey T. Leitch*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore Md.*

12 MAIDEN NAME OF MOTHER *Betsy E. Kimes*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore Md.*

14 Informant *Percey T. Leitch per Bill* (Address) *29 N. Carey St.*

15 Filed *Robert P. Harrison,* Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 13* 19 *20*

17 I HEREBY CERTIFY, That I attended deceased from

July 9, 19 *20*, to *July 13*, 19 *20*.

that I last saw him live on *July 13*, 19 *20*.

and that death occurred, on the date stated above, at *8:55 P.* m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos. *12* ds.

CONTRIBUTORY (Secondary) *Pneumonia*

(duration) yrs. mos. *8* ds.

18 Where was disease contracted *at home*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Diphtheria culture (+)*

(Signed) *Blufford* M. D.

7/14/20 (Address) *Sydenham Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Lorraine Ave *7-14-1920*

20 UNDERTAKER ADDRESS *17, 8*

Robert Brooks & Son *Calhoun St*

JUL 14 1920

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

10.44790

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.44790

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St Joseph Hospital* ST. *8* WARD)

2-FULL NAME *Paula Weaver*

(Residence in Baltimore: No. *2604 Preston St.*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. *3* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

Mar 6

1897

(Month)

(Day)

(Year)

7-AGE,

23

Yrs. mos. ds.

IF LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Domestic

9-BIRTHPLACE,

(State or Country),

Hancock, Md.

10-NAME OF FATHER,

George Weaver

11-BIRTHPLACE OF FATHER

(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Mary Dora

13-BIRTHPLACE OF MOTHER

(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ms J. G. Kelly

(Address)

Willow St Md.

15-

Robert P. Harrison,

JUL 14 1920

Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 15, 19*20*
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereof and from the evidence obtained by

and that said deceased came to death

The CAUSE OF DEATH* was as follows:

Killed by pistol

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John G. Kelly M. D.
(Coroner.)

7-74, 1917 (Address) *Willow St Md.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence *Hancock Md.*

19-PLACE OF BURIAL OR REMOVAL,

Hancock Md

DATE OF BURIAL,

July 15, 1920

20-UNDERTAKER

Robt J. Turner

ADDRESS

1442 N Broadway

D.44791

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.44791

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Duerick(a) RESIDENCE. No. 514 S. Bond St.ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds.How long in U. S., if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Unknown5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) Unknown7 AGE about Years Unknown 60 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown (State or country) Poland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)14 Informant Hospital Records,(Address) New City Hospital,15 Filed Robert F. Harrison,

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13, 19 2017 I HEREBY CERTIFY, That I attended deceased from July 13, 19 20, to July 13, 19 20.that I last saw him alive on July 13, 19 20.and that death occurred, on the date stated above, at 7:30 P.m.

The CAUSE OF DEATH* was as follows:

Colitis(duration) yrs. 7 mos. ds.CONTRIBUTORY (Secondary) Broncho-pneumonia(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? Yes.What test confirmed diagnosis? Autopsy findings(Signed) W. E. Steverson, M. D.7/14/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Rosary Cemetery July 15 19 20

20 UNDERTAKER

ADDRESS

John M. Weber 1803 Bank

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

JUL 14 1920

D44792

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 45

1044792

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hotel Altamont ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Dominie Spinoso

(a) RESIDENCE. No.

Hotel Altamont

ST.

WARD. Windber Pa.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

2

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofSarita Spinoso

6 DATE OF BIRTH (month, day, and year)

1874

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.46

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Coal Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Castellana, Italy

10 NAME OF FATHER

Francis Spinoso

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Italy

12 MAIDEN NAME OF MOTHER

Francisca

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Italy

14

Informant
(Address)Mariano Spinoso
Windber, Pa.

15

JUL 15 1920ROBERT E. KAUFMAN
RegistrarBurial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19 20

17

I HEREBY CERTIFY, That I attended deceased from July 13, 19 20, to July 14, 19 20, that I last saw him alive on July 14, 19 20, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:
Cancer of bladder

(duration) 6 yrs. + mos. + ds.

CONTRIBUTORY (Secondary)

(duration) + yrs. + mos. + ds.18 Where was disease contracted
If not at place of death?Did an operation precede death? No Date of NoWas there an autopsy? NoWhat test confirmed diagnosis? Cytoscopic examination(Signed) Dudley A. Roberts, M. D.15, 19 20 (Address) 1418 E. 16th St. H. Kelly, Hgt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Windber Pa7-15 1920

20 UNDERTAKER

Henry W. Jenkins & Sons CoW. J. Puller
Orchard

CAUSE OF DEATH in plain terms, so that it may be understood by laymen. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 Bank ST.; 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nicolas Nardone(Residence in Baltimore: No. 1405 Bank St.; 4 yrs., 4 mos., 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male4-COLOR OR RACE. White5-SINGLE, Married,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, May 3, 1918

(Month)

(Day)

(Year)

7-AGE, 2 yrs., 10 mos., 10 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country), Balt10-NAME OF FATHER, John Nardone11-BIRTHPLACE OF FATHER
(State or Country), NY12-MAIDEN NAME OF MOTHER Reynolds Ostuni13-BIRTHPLACE OF MOTHER
(State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Nardone(Address) 1405 Bank St.

15-

JUL 15 1920 ROBERT E. KAUTER
Filed....., 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 10, 1920

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from July 10, 1920, to July 10, 1920,
that I saw h— alive on July 6, 1920,
and that death occurred, on the date stated above, at 4 m.
The CAUSE OF DEATH* was as follows:CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) John Nardone

M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted,
if not at place of death?Former or
usual residence19-PLACE OF BURIAL OR REMOVAL, St. Vincent's Cem.DATE OF BURIAL, 7/15/20, 191...20-UNDERTAKER Wendell Klippel & SonADDRESS 278 Cum St.

important. See instructions on back of certificate.

1044794

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 Gorman av ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St. 28 yrs. 11 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Widow

6-DATE OF BIRTH

July 31, 1893.
(Month) (Day) (Year)

7-AGE,

36 yrs. 11 mos. 17 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

9-BIRTHPLACE,
(State or Country),

Baltimore Md

10-NAME OF FATHER,

Benjamin F Roberts

11-BIRTHPLACE OF FATHER
(State or Country),

Balto Md

12-MAIDEN NAME OF MOTHER

Henrietta Smith

13-BIRTHPLACE OF MOTHER
(State or Country),

Indiana

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Henrietta Schrieffer

(Address)

28 Gorman av

JUL 15 1920

ROBERT H. BRADTH

Filed....., 191..

BRIAL FORM 1-1917

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 14, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 1920, to July 13 1920

that I saw him alive on July 13 1920

and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
(Duration) 6 yrs. 6 mos. 17 ds.CONTRIBUTORY
(Secondary)

(Duration) 4 yrs. 6 mos. 17 ds.

(Signed)

Joseph E. Muse, M. D.
July 14 1920 (Address) 2520 Hollman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

London P K

DATE OF BURIAL,

July 17th 1920

20-UNDERTAKER

A. Jones

ADDRESS

207 S. Stricker

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

1044795

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044795

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 903 P 6th Highland)

ST.: 151 WARD)

2-FULL NAME

Auntie Catherine Knapp

(Residence in Baltimore: No. 903 P 6th St)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

July 13, 1930
(Month) (Day) (Year)

7-AGE,

14-LESS than 1 day,

yrs. mos. ds.

9 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Raymond J Knapp

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Ellen F. Grunwell

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Raymond J Knapp

(Address)

903 P 6th St

15-

JUL 15 1920

191

ROBERT E. KAUTEN

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 14, 1930
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry.)

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debitility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry J. Knapp, M. D.
(Coroner.)
7/15/30 (Address) 1610 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Mt. Carmel

DATE OF BURIAL,

July 13, 1930

20-UNDERTAKER

Zirkler & Zirkler

ADDRESS

1739 E.ager

N.B.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *North Pomer* ST. *8* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Maudie M. Hook*(a) RESIDENCE. NO. *1516 E Oliver St (2)* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *6* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Mr Hook* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *Aug 24, 1885*7 AGE Years *34* Months *11* Days *22* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Brooklyn N.Y.* (State or country)10 NAME OF FATHER *Philip Beehler*11 BIRTHPLACE OF FATHER (city or town) *Brooklyn N.Y.* (State or country)12 MAIDEN NAME OF MOTHER *Not Known*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant *Records of Mt Hope Reformatory* (Address)

15 JUL 15 1920 ROBERT E. ERAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 14 - 1920*17 I HEREBY CERTIFY, That I attended deceased from *June 3*, 1920, to *July 14*, 1920, that I last saw her alive on *July 14*, 1920, and that death occurred, on the date stated above, at *1:30 A.* m. The CAUSE OF DEATH* was as follows:*Chc. Tubercle Phthisis -**abt 5* or (duration) *6* yrs. *0* mos. *—* ds.CONTRIBUTORY *Recurrent mania* (Secondary)*since 1912* (duration) yrs. mos. ds.18 Where was disease contracted *Baltimore Md* if not at place of death?Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Frank J. Flannery*, M. D.*July 14*, 1920 Address) *Mt Hope Reformatory*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Parkwood Cem.**July 16, 1920*

20 UNDERTAKER

*Gurkle & Gurkle*ADDRESS *1739 Eager*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

1044797 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044797

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lombard & Green St. ST. 5 WARD)

2-FULL NAME

Ethel Enos

(a) RESIDENCE. NO.

251 N Exeter

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. - mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE White	5 Single, Married, Widowed, or Divorced (write the word) married
-----------------	--------------------------	---

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Walter Enos

6 DATE OF BIRTH (month, day, and year) June 15-1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	-	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

10 NAME OF FATHER Edw. Kelly

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Reubald

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.
(State or country)14 Informant Mrs. Annie Peterson
(Address) 251 N. Exeter St.15 Filed _____, 19 _____ ROBERT E. ERAUTER
Registrar

JUL 15 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 12, 1920, to July 13, 1920,

that I last saw him alive on July 13, 1920,

and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) J. M. Hurdley M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Vincent's Cemetery July 16 1920

UNDERTAKER ADDRESS

Geo. H. Gerbig 2001 W. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

1044798

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109

1044798

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sarah Trautmann(a) RESIDENCE. No. 710 McCab Ave St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced

(or) WIFE of

Sigmund Trautmann6 DATE OF BIRTH (month, day, and year) July 13 18587 AGE Years Months Days If LESS than 1 day, hrs. or min. 628 OCCUPATION OF DECEASED at home

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER William Frazier11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER M. Wilson13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant Sarah J. Trautmann (Address) 710 McCab Ave15 JUL 15 1920 ROBERT E. ELAETER BURIAL PERMIT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 7, 1920, to July 14, 1920,that I last saw him alive on July 14, 1920and that death occurred, on the date stated above, at 2:45 p.m.

The CAUSE OF DEATH* was as follows:

Central Nervous System (Post-operative)(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Intestinal Obstruction(duration) yrs. mos. ds. 10

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 7 & 8Was there an autopsy? NoWhat test confirmed diagnosis? Examine methods(Signed) [Signature], M. D.7/14, 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Landon Park Cemetery July 16 1920

20 UNDERTAKER ADDRESS

Chas. G. Black 742 W. North Ave

CAUSE OF DEATH in plain terms, as far as possible, on back of certificate. See instructions on back of certificates.

1044799

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044799
64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2208 E. Fairmont St. 6 WARD)

2-FULL NAME

Rachael Shugan

(a) RESIDENCE. NO.

2208 E. Fairmont St. 6 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

7

yrs.

mos.

ds.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth?

35

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of

Jacob Shugan

6 DATE OF BIRTH (month, day, and year)

1845

7 AGE

75

Years

Months

Days

If LESS than
1 day. hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant (Address)

J. Lewis 1411 E. Balto St.

15

Filed

JUL 15 1920

ROBERT E. LAUTER

Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 15 1920

17

I HEREBY CERTIFY, that I attended deceased from July 15 1920, to July 15 1920, that I last saw her alive on July 15 1920, at 12:15 am

and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

CONTRIBUTORY (Secondary)

Arterio-sclerosis (duration) 2 hrs. 10 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Receipt Testy M. D. 26 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hillview Rosedale

7-15 1920

20 UNDERTAKER

ADDRESS

Jack Lewis 1411 E. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

1044800

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ 1044800

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 332 S. Monroe St.

ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mervin LeRoy Harp

(a) RESIDENCE. No. 332 S. Monroe St.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE White	5 Single, Married, Widowed, or Divorced (write the word) Single
---------------	--------------------------	---

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 6/1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	---	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work None(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

10 NAME OF FATHER Martin J. Harp

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Helen Keller

13 BIRTHPLACE OF MOTHER (city or town) Cleveland
(State or country) Ohio.14 Informant Sarah E. Harp.
(Address) 332 S. Monroe St.15 Filed JUL 15 1920 ROBERT B. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1920

17 I HEREBY CERTIFY, That I attended deceased from

July 7 1920, to July 13 1920,

that I last saw him alive on July 13 1920,

and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Convulsions

CONTRIBUTORY (Secondary) Cholea Infantum 2 hours

18 Where was disease contracted
if not at place of death?

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis?

(Signed) W. A. O'Neill M. D.

7/14, 1920 (Address) 108 N. Butler Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Lorraine Cemetery.

DATE OF BURIAL

7/15/20,

20 UNDERTAKER

Joseph Bluck

ADDRESS

1003 N. B. St.

CAUSE OF DEATH is very important. See instructions on back of certificates.

1044801

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Filed

JUL 15 1920

ROBERT E. KRAUTER

BUTLER T. T. CLAY
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs. mos. ds.

(Signed) Frank E. Wagner M. D.

July 12, 1920 (Address) 1506 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

1303 PRESTMAN ST.

important. See instructions on back of certificate.

1044802

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044802

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Met Hope Retmar* ST.: *8* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

W. Jerome Bailey

(a) RESIDENCE. NO.

Baltimore - 2138 E. Olm St (?)

(Usual place of abode)

Length of residence in city or town where death occurred

2 1/2 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

2 1/2 yrs.

mos.

12 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

September 2, 1895

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

or min.

*24 1/2**8**12*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

William T. Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

New York City N. Y.

12 MAIDEN NAME OF MOTHER

J. May Barrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md

14

Informant (Address)

Records of Met Hope Retmar Met Hope Retmar

15

JUL 15 1920

ROBERT B. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 14 - 1920

17

I HEREBY CERTIFY, That I attended deceased from

*Oct 2 - 1918**July 14 - 1920*

that I last saw him alive on

July 14 - 1920

and that death occurred, on the date stated above, at

9:20 A.M.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

CONTRIBUTORY (Secondary)

(duration) *0* yrs. *0* mos. *3* ds.*Epilepsy (Cum Mania)*(duration) *5* yrs. *0* mos. *0* ds.

18 Where was disease contracted

if not at place of death?

Balto Md

Did an operation precede death?

No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Frank J. Lanning*, M. D.*July 14, 1920* (Address) *Met Hope Retmar*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral Cemetery**July 16, 1920*

20 UNDERTAKER

Henry Hoesch, Inc.

ADDRESS

1301 E. Eager St

CAUSE OF DEATH IN plain terms, so that it may be properly understood. See instructions on back of certificates.

1044803

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH.

7-AGE.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

Filed

JUL 15 1920

ROBERT S. TRAUTER

Bureau Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17-I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

244804

HEALTH DEPARTMENT—CITY OF BALTIMORE

1720 44804

CERTIFICATE OF DEATH.

PLACE OF DEATH Baltimore Dry Docks & Ship Building Co.
CITY OF BALTIMORE (No. South Plant. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William T. Hurley.

(Residence in Baltimore: No.

3510 Myrtle Place.

St.; yrs., 28 mos. 4 ds. 18

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married. (Write the word.)

6-DATE OF BIRTH, February 24th, 1892, / (Month) (Day) (Year)

7-AGE, 28 yrs., 4 mos., 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Riveter. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, Arthur T. Hurley.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER, Clara Thompson.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Hurley. (mother)

(Address) 3510 Myrtle Place.

JUL 15 1920

ROBERT E. KRAUTER

Filed

191

Baltimore, Md.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 12th, 1920, 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

inquiry and that said deceased came to his death (Inquest, au- topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Of the Skull.
Accidental fall from a scaffold.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Otto M. Reinhardt M. D. (Coroner.)

July 14, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Oak Lawn Cemetery July 15 1920

20-UNDERTAKER, ADDRESS

J. Herwig & Co. 2008 Orleans

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 E. Madison ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1630 E. Madison St.; 2 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE, <u>colored</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <u>Married</u>
6-DATE OF BIRTH, <u>not known</u> , <u>1866</u> (Month) (Day) (Year)		
7-AGE, <u>54</u> yrs., <u> </u> mos., <u> </u> ds.		If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work, <u>book</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u> </u>		

9-BIRTHPLACE,
(State or Country),Virginia

PARENTS.

10-NAME OF FATHER,

Wm. Upsheer11-BIRTHPLACE OF FATHER
(State or Country),Virginia

12-MAIDEN NAME OF MOTHER

Amanda Upsheer13-BIRTHPLACE OF MOTHER
(State or Country),Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hannah Bolden(Address) 1630 E. Madison St.

15-

JUL 15 1920

ROBERT E. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July, 14, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 14th 1920 to July 14 1920, that I saw her alive on July 13th 1920, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. E. Thomas M. D.7-15, 1920 (Address) 822 N. Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

King William July 15 1920

20-UNDERTAKER

ADDRESS

P. B. Gross 1415 McElderry

CAUSE OF DEATH—Fill out on back of certificate. Important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE important. See instructions on back of certificate.

244806 *Scotton* HEALTH DEPARTMENT—CITY OF BALTIMORE *244806*

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *3109 Westwood Ave* ST. *15* WARD) REGISTERED No. C
2-FULL NAME *Frank Trotton*
(Residence in Baltimore: No. *3109 Westwood Ave* St. *15* mos. *28* ds.)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *widow*
(Write the word.)
6-DATE OF BIRTH, *August 5, 1858*
(Month) (Day) (Year)
7-AGE, *61* yrs. *11* mos. *9* ds. If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *letter carrier (retired)*
(b) General nature of industry, business, or establishment in which employed (or employer), *U.S.P.O.*

9-BIRTHPLACE, (State or Country), *Balto. Md.*
PARENTS.
10-NAME OF FATHER, *Benjamin Trotton*
11-BIRTHPLACE OF FATHER, (State or Country), *Balto. Md.*
12-MAIDEN NAME OF MOTHER, *Ellen Merritt*
13-BIRTHPLACE OF MOTHER, (State or Country), *Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Mr. E. D. Mitchell*
(Address) *3109 Westwood Ave*

15- *ROBERT E. LAUTER*
Filed *JUL 15 1920* *BALTIMORE*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 14, 1920*
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) *5* yrs. *5* mos. *5* ds.
CONTRIBUTORY (Organic heart disease) (Secondary)
(Duration) *1* yrs. *1* mos. *1* ds.
(Signed) *J. D. Hennessy* M. D.
(Coroner.)
July 14, 1920 (Address) *2802 Edwardsman*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place In the
of death...yrs...mos...ds. State...yrs...mos...ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Landon Park* DATE OF BURIAL, *July 16, 1920*
20-UNDERTAKER, *William G. E.* ADDRESS, *1737 Lytle Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1214 N Chester* ST.;REGISTERED NO. C. *41*WARD) *8*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1214 N. Chester* ST.St.: *62* yrs., *9* mos. *12* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) *Widower*

6-DATE OF BIRTH,

Sept *30*, *1857*.
(Month) (Day) (Year)

7-AGE,

62 yrs. *9* mos. *12* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*Machinist*9-BIRTHPLACE,
(State or Country),*Baltimore Md*

10-NAME OF FATHER,

John A. Offley

11-BIRTHPLACE OF FATHER

(State or Country),

Baltimore Md

12-MAIDEN NAME OF MOTHER

Lash B. Perkins

13-BIRTHPLACE OF MOTHER

(State or Country)

Wilmington Del.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harry Offley*(Address) *1214 N. Chester St.*

JUL 15 1920

Filed..... 191

ROBERT E. KAUFER

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July *13*, *191*^{*20*}...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March *191*^{*20*}, to *July* *191*^{*20*},that I saw him alive on *July 12* *191*^{*20*},and that death occurred, on the date stated above, at *9:30 A. m.*

The CAUSE OF DEATH* was as follows:

Intestinal Carcinoma
(Duration)..... yrs. *8* mos. ds.CONTRIBUTORY
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) *Frank J. Ayd**July 13*, *191*^{*20*} (Address) *2045 E. Monument St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Cemetery *July 16*, *191*^{*20*}

20-UNDERTAKER

ADDRESS

William G. Schaeffer *816 E. Monument St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Emily Horsey*(a) RESIDENCE. NO. *Sykesville Md*

(Usual place of abode)

WARD. *Sykesville Md*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

14

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1845*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

75

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Maryland*10 NAME OF FATHER *Henry Horsey*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*England*12 MAIDEN NAME OF MOTHER *H. Horsey*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

*Jas. Crooks
Richmond Va*

15

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 15 1920*

17

I HEREBY CERTIFY, That I attended deceased from

July 7, 19*20*, to *July 15*, 19*20*
that I last saw her alive on *July 15*, 19*20*and that death occurred, on the date stated above, at *11:30 A.M.*

The CAUSE OF DEATH* was as follows:

Carcinoma of the Gall bladder(duration) yrs. *6* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *8*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *July 8, 1920*Was there an autopsy? *No*What test confirmed diagnosis? *Apical method*

(Signed)

7/15/20 (Address) *University & Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt. View Cemetery**July 17 1920*

20 UNDERTAKER

ADDRESS

*Jas. R. Mead**Sykesville Md*

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, or the plain translation of the technical terms, on back of certificates. See instructions on back of certificates.

JUL 15 1920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *704 Redwood*)ST.: *13* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *704 Redwood*

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *40* yrs. mos. ds.How long in U. S., if of foreign birth? *40* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

*married*5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —6 DATE OF BIRTH (month, day, and year) *March 2nd 1854*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*66 yrs.**4**11*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

Coca-Cola & Fayette St.

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Germany*

10 NAME OF FATHER

Anton Noeth

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant
(Address)*Mrs Noeth
704 Redwood St.*

JUL 15 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *7/13/20* 19

17

I HEREBY CERTIFY, That I attended deceased from

7/11/20, 19, to *7/13/20*, 19that I last saw him alive on *7/13/20*, 19and that death occurred, on the date stated above, at *9 P.* m.

The CAUSE OF DEATH* was as follows:

Chr. diff. hepatitis(duration) *within* yrs. mos. ds.CONTRIBUTORY
(Secondary)*Cerebral Hemorrhage*
(duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Bernard J. Terry*, M. D.No. 19 (Address) *910 W. 4th St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Peter's Cemetery**July 16th 1920*

20 UNDERTAKER

ADDRESS

*John J. Lowman & Son**704 Redwood St.*

D. 44811 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *409 Colvin*)ST.: *5*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Margaret Stevenson

(a) RESIDENCE. NO.

409 Colvin

ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *45* yrs.

mos.

How long in U. S., if of foreign birth? *45* yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Mr. Stevenson

6 DATE OF BIRTH (month, day, and year)

June 20-1860

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*60**22*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House

(b) General nature of industry, business, or establishment in which employed (or employer)

Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

John Mallen

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Mr. Stevenson 409 Colvin St.

15

Filed

*15 1920**Robert P. Harrison,*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 12 1920

17

I HEREBY CERTIFY, That I attended deceased from

*February 1919 to July 13, 1920,*that I last saw him alive on *July 12, 1920,*and that death occurred, on the date stated above, at *11 P.m.*

The CAUSE OF DEATH* was as follows:

Exhaustion of Heart.
and general degenerative
condition of Abdominal viscera

(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *none*(Signed) *Benj. P. Hayden M. D.**7/14 1920* (Address) *1214 N. Caroline St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cathedral**July 17 1920*

20 UNDERTAKER

ADDRESS

H. C. Wiedefeld 914 Green St.

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1603 Hanover* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1603 Hanover* St.; *42* yrs., *8* mos., *14* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Widowed*

6-DATE OF BIRTH.

Oct 29, 1856
(Month) (Day) (Year)

7-AGE.

63 yrs. 8 mos. 14 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Home work*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Germany

10-NAME OF FATHER.

John P. Leach

11-BIRTHPLACE OF FATHER (State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Unmarried

13-BIRTHPLACE OF MOTHER (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Caroline P. Leach
1603 Hanover St.

15-

*Jul 15, 1920**Robert P. Harrison,*

191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 13, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended, deceased from *June 25, 1920*, to *July 13, 1920*, that I saw him alive on *July 12, 1920*, and that death occurred, on the date stated above, at *12:30 p.m.*
The CAUSE OF DEATH* was as follows:
a auto cardiac dilatation

CONTRIBUTORY

(Secondary)

(Signed)

7/13/20

(Address)

1603 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. *42* yrs. *8* mos. *14* ds. In the State *42* yrs. *8* mos. *14* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Greenwood Park Cem.

DATE OF BURIAL.

July 16, 1920

ADDRESS

1039

20-UNDERTAKER

*Ed. Schuman**Charmouth*

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S.P.H.S. Hospital #56, Ft. McHenry, Md. REGISTERED NO. C
 CITY OF BALTIMORE: (No. ST.; 24 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 2-FULL NAME William G. Glawson,
 (Residence in Baltimore: No. U.S.P.H.S. Hospital #56, Ft. McHenry, Md. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male	4-COLOR OR RACE, White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single
6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)		
7-AGE, 47 yrs., mos., ds.		If LESS than 1 day, hours or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. Seaman (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE, (State or Country), Boston, Mass.		
PARENTS.	10-NAME OF FATHER, Unknown	
	11-BIRTHPLACE OF FATHER (State or Country), Unknown	
	12-MAIDEN NAME OF MOTHER Unknown	
	13-BIRTHPLACE OF MOTHER (State or Country), Unknown	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar J. Reinhardt
 (Address) U.S.P.H.S. #56

15-

July 15 1920 Robert P. Harrison,
 Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,
 July 13, 1920.
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
 July 2, 1920, to July 13, 1920,
 that I saw him alive on July 13, 1920,
 and that death occurred, on the date stated above, at 5:40 P.m.
 The CAUSE OF DEATH* was as follows:

1. Tabes dorsalis.
 2. General paralysis of Insane.
 (Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary)
 (Duration) yrs., mos., ds.

(Signed) Thomas R. Payne M. D.
 July 15, 1920 (Address) Ft. McHenry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS

July 15, 1920
 Robert P. Harrison, Registrar.

D. 44814

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 44814

CERTIFICATE OF DEATH.

138-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Johns Hopkins Hosp. St.* *7th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Dorothy White

(a) RESIDENCE. NO.

230 Jefferson St. City

WARD.

Washington D.C.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 1st

7 AGE

Years

Months

Days

If LESS than 1 day,.....hrs.

or.....min.

*22**7**1*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House-work - 027

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

D.C.

10 NAME OF FATHER

Benjamin Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Julia Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

G. M. Reese

15

Filed

Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 14th 1920

17

I HEREBY CERTIFY, That I attended deceased from *June 14th 1920* to *July 14th 1920* that I last saw her alive on *July 14th 1920*.and that death occurred, on the date stated above, at *8:45 A.M.*

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia(duration) yrs. mos. *7* ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia(duration) yrs. mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *John W. Harris*, M. D.Address *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Cause, state (1) means and Nature of Injury, and (2) whether accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Washington D.C.**July 15, 1920*

20 UNDERTAKER

Mrs Robert Elliott

ADDRESS

1728

CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1351 N. Calhoun ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Eliza Ann Brown

(a) RESIDENCE. No.

1351 N. Calhoun

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

60 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

15 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofLate William H. Brown

6 DATE OF BIRTH (month, day, and year)

Aug 5 - 1832

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.87 11 8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Montgomery Co.

10 NAME OF FATHER

Henson Dorsey11 BIRTHPLACE OF FATHER (city or town)
(State or country)Montgomery Co.

12 MAIDEN NAME OF MOTHER

Mary Powell13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Montgomery Co.

14

Informant
(Address)Emma A. Brown
1351 Calhoun

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 13 19 20

17

I HEREBY CERTIFY, That I attended deceased from

May 12, 1919, to July 13, 19 20.that I last saw her alive on July 13, 19 20.and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial
nephritis (duration) 3 yrs. 7 mos. 7 ds.CONTRIBUTORY
(Secondary)Senility (duration) 1 yrs. 1 mos. 1 ds.

18 Where was disease contracted

if not at place of death?

1351 W. CalhounDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Urinary Analysis(Signed) Wm. H. Wright, M. D.Address 1209 P. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn7-14 19 20

20 UNDERTAKER

ADDRESS

Sam'l. H. Chase 1460 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

JUL 15 1920

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Johns Hopkins Hospital ST.: *5*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Essie Telp.

(a) RESIDENCE. NO.

201 Colvin Street

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mathew Telp

6 DATE OF BIRTH (month, day, and year)

March 15-1899

7 AGE

21

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Georgia

10 NAME OF FATHER

Mont Tinsley

11 BIRTHPLACE OF FATHER (city or town)

Georgia

(State or country)

12 MAIDEN NAME OF MOTHER

Nancy Carpenter

13 BIRTHPLACE OF MOTHER (city or town)

Georgia

(State or country)

14

Informant (Address)

Hospital Records J 21 26

15

Filed 15 1920

R. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 13 1920

17

I HEREBY CERTIFY, That I attended deceased from

*July 12, 1920, to July 13, 1920.*that I last saw her alive on *July 13, 1920.*and that death occurred, on the date stated above, at *3:20 P. m.*

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Peric abscess

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

yes Date of July 13 20

Was there an autopsy?

No.

What test confirmed diagnosis?

(Signed)

W. H. Shaw

M. D.

(Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*UNIVERSITY OF MARYLAND.**July 15 1920*

20 UNDERTAKER

ADDRESS

Commissioner Health.

Burial Permit Clerk.

D.44817

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.44817

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3423 Roland Ave. ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Agnes Morris

(a) RESIDENCE. NO.

3423 Roland Ave. ST. 13 WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

12-21-1870

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

49620

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

James Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Kate Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Agnes Powers
3423 Roland Ave.

JUL 15 1920

Filed

Robert B. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH*

16 DATE OF DEATH (month, day, and year)

7-13 1920

17

I HEREBY CERTIFY, That I attended deceased from

Sept 15, 1912, to July 13, 1920that I last saw her alive on July 13, 1920.and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cancer of Stomach

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 8-12-15Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

H. P. Powers

M. D.

, 19 (Address)

921 N. Chas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Catholic Cemetery7-16 1920

20 UNDERTAKER

Chas. F. Evans, Inc.

ADDRESS

118 N. W. 1st St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1378 W. North an St.; 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1378 W. North an St.; 52 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

F

4-COLOR OR RACE,

W5-SINGLE,
MARRIED, married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

March 3, 1857
(Month) (Day) (Year)

7-AGE,

63 yrs., 4 mos., 11 ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....Housewife9-BIRTHPLACE,
(State or Country),Germany10-NAME OF
FATHER,Emanuel Klein11-BIRTHPLACE
OF FATHER
(State or Country),Germany12-MAIDEN NAME
OF MOTHERAmelia Klein13-BIRTHPLACE
OF MOTHER
(State or Country),Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emanuel Klein(Address) 514 Sanford Pl.

15-

Robert P. Harrison,

191.....

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 1, 1920, to July 14, 1920,that I saw ha alive on July 14, 1920,and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis(Duration).....yrs.....6 mos.....ds.CONTRIBUTORY
(Secondary)(Duration).....yrs.....mos.....3 ds.(Signed).....Frederick Lutz.....M. D.July 15, 1920. (Address) 7040 Eutan Pl.State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANS-
IENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore GeneralJuly 16, 1920

20-UNDERTAKER

ADDRESS

J. Ahrens & Co1611 Madisonme

important. See instructions on back of certificate.

JUL 15 1920

D. 44819 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 44819

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

West End Maternity

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mrs. Irene Jones

(Residence in Baltimore: No.

625 E. Fort ave.

St.; 94 yrs., 3 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

F.

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

April

1

1896

(Month)

(Day)

(Year)

7-AGE,

24-3 12

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,

(State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Frederick Terrell

11-BIRTHPLACE OF FATHER,

(State or Country),

Baltimore, Md.

12-MAIDEN NAME OF MOTHER,

Johnanna Kruse

13-BIRTHPLACE OF MOTHER,

(State or Country),

Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Hospital Record

(Address)

15-

JUL 15 1920

Robert B. Harrison

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

13

1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 13 1920, July 13 1920,

that I saw her alive on July 13 1920,

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Eclampsia

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. Harrison M. D.

July 13 1920 (Address) 103 W. 22nd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western Cem.

DATE OF BURIAL, July 16, 1920

20-UNDERTAKER

M. L. Flynn

ADDRESS 1422 Light

important. See instructions on back of certificate.

044820

Jasnowski
HEALTH DEPARTMENT—CITY OF BALTIMORE

044820

105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

418 S. Patterson Park Ave 1

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Wilm Jasnowski

(a) RESIDENCE. NO.

418 S. Patterson Park Ave

1 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 3 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

none

6 DATE OF BIRTH (month, day, and year)

Feb 24-1917

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Wm Jasnowski

11 BIRTHPLACE OF FATHER (city or town)

Phila

(State or country)

Pa

12 MAIDEN NAME OF MOTHER

Josephine Brodzinski

13 BIRTHPLACE OF MOTHER (city or town)

Balt

(State or country)

14

Informant (Address)

Wm Jasnowski
408 S. Patterson Park Ave

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 15 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 2, 1920, to July 14, 1920,

that I last saw him alive on July 14, 1920,

and that death occurred, on the date stated above, at 11:52 p. m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis - Colitis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed)

A. F. Rios

M. D.

July 15 1920 (Address)

24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary Cem

July 16 1920

20 UNDERTAKER

ADDRESS

Stephen J. Frachowski

1000 Skinner St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 15 1920

N. B.—Every item of information should be carefully supplied. Age should be stated in years, months, and days. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE		10.44821	
CERTIFICATE OF DEATH			
1 PLACE OF DEATH		REGISTERED NO. C	
CITY OF BALTIMORE (No. 1506 1/2 N. Gay St.)		WARD 8	
2 FULL NAME John H. Schubert		(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)	
(Residence in Baltimore: No. 1506 1/2 N. Gay St.)		St. 1506 1/2 N. Gay St. yrs. mos. ds.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX Male	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single	
6 DATE OF BIRTH September 19, 1873 (Month) (Day) (Year)			
7 AGE 46 yrs. 9 mos. ds. If LESS than 1 day, hrs. min.?			
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Mushmaker			
9 BIRTHPLACE (State or country) Baltimore Md			
PARENTS	10 NAME OF FATHER Henry Schubert		
	11 BIRTHPLACE OF FATHER (State or country) Baltimore		
	12 MAIDEN NAME OF MOTHER Elizabeth Drummond		
	13 BIRTHPLACE OF MOTHER (State or country) Germany		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. Mamie Boxley, (Address) 1506 1/2 N. Gay St.			
15 JUL 15 1920 Robert P. Harrison, Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH July 13, 1920 (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from June 10, 1920 to July 13, 1920 that I saw him alive on July 13, 1920 and that death occurred, on the date stated above, at 2 P. m. The CAUSE OF DEATH* was as follows: Cancer of Throat			
Contributory (SECONDARY) Acthenia (Duration) yrs. 2 mos. ds.			
(Signed) William F. Hanger M. D. (Address) 1407 N. Gay St.			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL Holy Rosary Cem.		DATE OF BURIAL July 16, 1920	
20 UNDERTAKER Geo. J. Puth		ADDRESS 1735 - Hartford	

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 44822		HEALTH DEPARTMENT--CITY OF BALTIMORE		D. 44822	
		CERTIFICATE OF DEATH			
PLACE OF DEATH		CITY OF BALTIMORE (No. <u>3405 Greenmount Ave</u> ST. <u>9</u> WARD)		REGISTERED No. C	
FULL NAME <u>Beatrice B. Healy</u>		(Residence in Baltimore: No. <u>Life Lane</u> St. <u>about 50 yrs</u> yrs. mos. ds.)		(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>Oct 14</u> , 1863 (Month) (Day) (Year)					
7 AGE <u>56</u> yrs. <u>9</u> mos. <u>—</u> ds. or min.?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House duties</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Ireland</u>					
PARENTS					
10 NAME OF FATHER <u>Patrick J. Finn</u>					
11 BIRTHPLACE OF FATHER <u>Ireland</u>					
12 MAIDEN NAME OF MOTHER <u>Annea Madden</u>					
13 BIRTHPLACE OF MOTHER <u>Ireland</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Sarah M. May Healy</u> (Address) <u>3405 Greenmount Ave</u>					
15 <u>15</u> 1920 Robert P. Harrison, Burial Permit Clerk REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>July 14</u> , 1920 (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>about 3³⁰</u> , 191 <u>—</u> , to <u>July 14</u> , 1920, that I saw him alive on <u>July 14</u> , 1920, and that death occurred, on the date stated above, at <u>8:20 P.M.</u> The CAUSE OF DEATH* was as follows: <u>Cancer of Uterus "Sarcoma"</u> <u>about</u> (Duration) <u>3</u> yrs. mos. ds. Contributory (SECONDARY) (Signed) <u>H. G. Orentlich</u> M. D. <u>July 15</u> , 1920 (Address) <u>634 Greenmount Ave</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, If not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>St Mary's Covane</u> DATE OF BURIAL <u>July 17</u> , 1920					
20 UNDERTAKER <u>L. P. Russellbaugh</u> ADDRESS <u>2620 St Paul St</u>					

10,44823 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *16 N. Wolfe St. - Baltimore* WARD. *Pennock Va*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *3* mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

x

6 DATE OF BIRTH (month, day, and year)

Dec 29 - 1916

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Walter Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Theresa

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

J. H. Bonds

15

File

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 15* 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 7, 1920, to *July 15*, 1920.

that I last saw him alive on *July 15*, 1920.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

1. *Nasal Diphtheria*

2. *Bacillary Dysentery*

3. *Pulmonary tuberculosis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Ecthyra

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Pts. home*

Did an operation precede death? *no* Date of

Was there an autopsy? *yes*

What test confirmed diagnosis?

(Signed) *Wm. H. H. H.* M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

July 16 1920

20 UNDERTAKER

Martin D. Dippel

ADDRESS

372 E. ...

CAUSE OF DEATH is very important. See instructions on back of certificates.

JUL 15 1920

10.44824 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.44824

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 S. Central Ave 3 ST.; 3 WARD)

2-FULL NAME

(Residence in Baltimore: No. 405 S. Central Ave St.; 7 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Oct 25, 1905
(Month) (Day) (Year)

7-AGE,

14 yrs. 8 mos. 1 da.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Baltimore Ind

10-NAME OF FATHER,

Louis Schiaffino

11-BIRTHPLACE OF FATHER
(State or Country),

Italy

12-MAIDEN NAME OF MOTHER

Mary Castagnoli

13-BIRTHPLACE OF MOTHER
(State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Schiaffino

(Address) 405 S. Central Ave

15-

Filed JUL 15 1920 191... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1920, to July 15, 1920,

that I saw him alive on July 14, 1920,

and that death occurred, on the date stated above, at 8:50 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
Chronic Aortic and Mitral Insufficiency

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Eugene L. Pearson M. D.

July 15, 1920 (Address) 2319 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Holy Redeemer July 16, 1920

20-UNDERTAKER

ADDRESS

Martin W. E. Dippel 375 Union St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2812 Harlem Ave 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Annie Baron(Residence in Baltimore: No. 2812 Harlem Ave St.; 60 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH,

Nov. 1, 1843
(Month) (Day) (Year)

7-AGE,

76 yrs., 8 mos., 21 da.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None
at home

9-BIRTHPLACE, (State or Country),

A. A. Co. Md.

PARENTS.

10-NAME OF FATHER,

John Lowman

11-BIRTHPLACE OF FATHER (State or Country),

Don't know.

12-MAIDEN NAME OF MOTHER

Sallie Burnett

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Hodges(Address) 2812 Harlem Ave.

15-

JUL 16 1920C. H. Grese.

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 13, 1920.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Apr 10 1920, to July 13 1920, that I saw her alive on July 13 1920, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Haemophlegma
complicated by Gastric
Emphysema (Duration) 7 yrs., 7 mos., 7 da.

CONTRIBUTORY (Secondary)

Edema of Lungs (Duration) 7 yrs., 7 mos., 7 da.(Signed) John W. Tinsel M. D.July 14, 1920 (Address) 1219 Taylor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ✓ yrs. ✓ mos. ✓ da. In the ✓ State ✓ yrs. ✓ mos. ✓ da.Where was disease contracted, if not at place of death? ✓Former or usual residence ✓

19-PLACE OF BURIAL OR REMOVAL,

Mt. Olivet Cem.

DATE OF BURIAL,

July 16, 1920

20-UNDERTAKER

Mr. Mrs. John W. Tinsel

ADDRESS

801 W. Fayette St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 Plum al St.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augustus S. Thomas(Residence in Baltimore: No. 925 Plum al St. 33 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Col5-SINGLE,
MARRIED, Widower
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

March 18, 1867
(Month) (Day) (Year)

7-AGE,

53 yrs. mos. ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).....9-BIRTHPLACE,
(State or Country),Md.10-NAME OF
FATHER, William Thomas11-BIRTHPLACE
OF FATHER
(State or Country), Md12-MAIDEN NAME
OF MOTHER unknown13-BIRTHPLACE
OF MOTHER
(State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bailey Thomas(Address) 925 Plum al

15-

JUL 16 1920 G. H. Grese.

Filed..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July, 15, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
July 12 1920, to July 15 1920,
that I saw him alive on July 15 1920,
and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial
Pneumonia
(Duration) 3 yrs. mos. ds.CONTRIBUTORY Acute Degeneration
(Secondary) of Heart(Signed) W. S. Lawrence M. D.
7/15, 1920 (Address) 140 N Hill St*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS-
FERENTS, OR RECENT RESIDENTS).At place of death yrs. mos. ds. In the State yrs. mos. ds.Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn et

DATE OF BURIAL,

July 18, 1920

20-UNDERTAKER

A. L. Brown & Son 108 W. Mt. Rd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Hicks

(a) RESIDENCE. No. 1538 N. Carey St. ST., _____ WARD. _____

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE Years Months Days 42 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER Anthony Hicks

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records,

(Address) New City Hospital.

15 JUL 16 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13, 1920

17 I HEREBY CERTIFY, That I attended deceased from November 19, 1913, to July 13, 1920, that I last saw h. ex alive on July 13, 1920, and that death occurred, on the date stated above, at 11:15 A.m. The CAUSE OF DEATH* was as follows:

Epilepsy.

(duration) 1.5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? No special test.

(Signed) W. J. Sherman, M. D.

7/13/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

MT Auburn Ct

July 16 1920

20 UNDERTAKER

ADDRESS

L. H. Brown Son of W. W. Monty

CAUSE OF DEATH IN PLAIN TERMS, See instructions on back of certificates. TION is very important.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. See instructions on back of certificate.

244828 HEALTH DEPARTMENT—CITY OF BALTIMORE 167 244828

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *John Hopkins Hospital* REGISTERED NO. C
CITY OF BALTIMORE (No. *St. WARD*)
2-FULL NAME *Alfred Mc Cleary Hinkle* (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(Residence in Baltimore: No. *2716 Jefferson St.* St.; yrs., *5* mos. *7* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
6-DATE OF BIRTH *Nov 29*, 1914 (Month) (Day) (Year)
7-AGE *5* yrs. *7* mos. *17* ds. If LESS than 1 day, ...hrs. or...min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE (State or Country), *Ind.*
10-NAME OF FATHER *William J. Hinkle*
11-BIRTHPLACE OF FATHER (State or Country), *Ind.*
12-MAIDEN NAME OF MOTHER *Henriette A. Schaufel*
13-BIRTHPLACE OF MOTHER (State or Country), *Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Wm J. Hinkle*
(Address) *2716 Jefferson St.*

15-*JUL 16 1920* *G. H. Grese.*
Filed. 101. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Jan 14*, 1920 (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and from the evidence obtained by said inquest, and that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Burns white & legs
and head fire
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
(Signed) *A. J. Miller* M. D. (Coroner.)
7-15, 191 (Address) *2334 Jefferson St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Linden Park Cem.* DATE OF BURIAL, *July 17 1920*
20-UNDERTAKER *Mrs. C. Miller* ADDRESS *2334 Jefferson St.*

N. B.—Every item of information is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

44829

CERTIFICATE OF DEATH.

79 44829

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2239 McElday ST. 7 WARD)

2-FULL NAME Frederick Hess

(Residence in Baltimore: No. 2239 McElday

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

66 6 20
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

single

6-DATE OF BIRTH,

Jan 24, 1854
(Month) (Day) (Year)

7-AGE,

66 yrs. 6 mos. 20 ds.

It LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Sanitarian

9-BIRTHPLACE,
(State or Country),

Maryland

10-NAME OF FATHER,

Henry Hess

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Elizabeth Gersler

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

August Hess

(Address)

2239 McElday

15-

JUL 16 1920

G. H. Grese.

Filed..... 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 14, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Signed)..... M. D.

7-16-20 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn Cemetery

DATE OF BURIAL,

July 16 1920

20-UNDERTAKER

Mrs. C. Miller

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

244830

244830

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

77 E. Montgomery ST. WARD 22

2-FULL NAME

James E. Fitzpatrick

(a) RESIDENCE. No.

77 E. Montgomery ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced—HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

JUL 16 1920 G. H. Grese

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

7/14 1920

17

I HEREBY CERTIFY, That I attended deceased from one year, 1919, to 7/14 1920, that I last saw him alive on 7/14 1920.

and that death occurred, on the date stated above, at 1030 A.M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. E. Smith M. D.

9/10 1920 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N.B.—Every item of information should be carefully checked for accuracy. Exact statement of OCCUPATION very important. See instructions on back of certificate.

244831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Day no. 16*
CITY OF BALTIMORE (No. *1411 Market* ST. *16* WARD)
2-FULL NAME *Mayan Murchison*
(Residence in Baltimore: No. *1411 Market St*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. *1* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *Weyn* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*
6-DATE OF BIRTH, *Amerson, 1882*
(Month) (Day) (Year)
7-AGE, *38* yrs. *3* mos. *1* ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Eng. Fireman*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Danforth N.C.*
PARENTS.
10-NAME OF FATHER, *unknown*
11-BIRTHPLACE OF FATHER (State or Country), *unknown*
12-MAIDEN NAME OF MOTHER, *unknown*
13-BIRTHPLACE OF MOTHER (State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Eva Murchison*
(Address) *1411 Market St*

15- *JUL 16 1920* *G. H. Grese.*
Filed. *1920* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 14, 1920*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *investigation* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *investigation* (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Natural Causes
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Signed) *Henry J. Smith* M. D. (Coroner)
7/15, 19*20* (Address) *1600 E. 13th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence
19-PLACE OF BURIAL, OR REMOVAL, *Calvary Cem* DATE OF BURIAL, *July 16, 1920*
20-UNDERTAKER *Samuel H. Hardy* ADDRESS *578*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation important. See instructions on back of certificate.

844832 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 735 George St. 17 WARD)

2-FULL NAME Clara Myers

(Residence in Baltimore: No. 735 George St. 75 yrs. mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, 7-AGE, 8-OCUPATION:

9-BIRTHPLACE, 10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER, 12-MAIDEN NAME OF MOTHER, 13-BIRTHPLACE OF MOTHER

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) (Address)

15- Filled JUL 16 1920 G. H. Grese. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. E. Hennessey, M. D. (Coroner.)

(Address) 2802 Euphonia Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE, HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-DATE OF BURIAL OR REMOVAL, DATE OF BURIAL, 20-UNDERTAKER, ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 S Montford Ave! WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Hilgeman(a) RESIDENCE. No. 711 S Montford Ave WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Henry Hilgeman6 DATE OF BIRTH (month, day, and year) Jan. 15 1865

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

65530

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Housewife

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

John Hilgeman

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Henry Hilgeman
711 S Montford Ave

15

File

JUL 16 1920G. H. Grese

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 192017 I HEREBY CERTIFY, That I attended deceased from March 5 - 19 20, to July 13 - 19 20,that I last saw her alive on July 13 - 19 20, and that death occurred, on the date stated above, at 6.30 P.m.

The CAUSE OF DEATH* was as follows:

Suppurative nephritis - following cystitis

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 1 mos. 1 ds.(duration) 1 yrs. 1 mos. 1 ds.18 Where was disease contracted? ☒ If not at place of death?Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? usual(Signed) H. Grese, M. D.

19 (Address)

125 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Carmel Cem.July 16 1920

20 UNDERTAKER

Heander Sons

ADDRESS

1710 1/2 E. 1st St.

CAUSE OF DEATH IN PART TO BE WRITTEN IN INSTRUCTIONS ON BACK OF CERTIFICATES. See instructions on back of certificates. TION is very important.

D 44834 HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2671 Fred On ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edward L. Buckert

(a) RESIDENCE. No. 2671 Fred On ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 28-1907

7 AGE Years 13 Months 2 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

John Buckert

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Margaret Grese

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Margaret Goodenough 2671 Fred On

15

Filed JUL 16 1920 G. H. Grese.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 13, 1920, to July 15, 1920,

that I last saw him alive on July 15, 1920,

and that death occurred, on the date stated above, at 8.4. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Typhoid fever

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Don't know

Did an operation precede death?

no

Date of

Was there an autopsy?

What test confirmed diagnosis?

Clinical symptoms

(Signed)

Harold H. Hall

M. D.

7/15/1920 Address

2027 Mount N

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Olivet

July 16 1920

20 UNDERTAKER

H. M. Cook

ADDRESS

148 Mt.

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

844835

844835

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH.

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD)

WARD.

(If nonresident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14

Informant (Address)

15

File

JUL 16, 1920

G. H. Grese.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from July 5, 1920, to July 15, 1920, that I last saw him alive on July 15, 1920, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates. TION is very important.

Hankey
HEALTH DEPARTMENT—CITY OF BALTIMORE

844836

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Church Home & Infirmary*CITY OF BALTIMORE: (No. *26 N. Broadway* ST.: *10* WARD)2-FULL NAME *Mrs. Emma Hankey*(a) RESIDENCE. NO. *1118 E. Monument* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

*White*5 Single, Married, Widowed,
or Divorced (write the word)*Widowed*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*late George C. Hankey*

6 DATE OF BIRTH (month, day, and year)

Don't know

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*about 58*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*at home*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Balto Md*

10 NAME OF FATHER

*Don't know*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Germany*

12 MAIDEN NAME OF MOTHER

*Don't know*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*" "*

14

Informant
(Address)*George L. Hankey
1823 N. Castle St*

15

Filed

JUL 16 1920 G. H. Grese.

Registrar

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 10 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 8-14 1920, 1920, to July 15, 1920,

that I last saw her alive on

July 15, 1920

and that death occurred, on the date stated above, at

1.10 a. m.

The CAUSE OF DEATH* was as follows:

① *Unbleeding Stomach*② *Chronic Nephritis*③ *Hypertension & Arteriosclerosis*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)*Pulmonary Edema*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Yes

Date of

July 12-1920

Was there an autopsy?

No

What test confirmed diagnosis?

Exam. Lab. & Op.

(Signed)

Walter S. Anderson M.D.

, 19

(Address)

*C.H.S.**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore

DATE OF BURIAL

July 17 1920

20 UNDERTAKER

William Cook

ADDRESS

502 S. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.: *108* WARD)REGISTERED NO. *44837*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Reese Lake*(a) RESIDENCE. NO. *Mumery Lane* ST.: *Edmondson Ave.* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 23 - 1904*

7 AGE

15

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Pleasantville N. J.*10 NAME OF FATHER *Engene T. Lake*11 BIRTHPLACE OF FATHER (city or town) (State or country) *N. J.*12 MAIDEN NAME OF MOTHER *Esther Reese*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *N. J.*

14

Informant (Address)

Engene T. Lake
1000 E. Cantonville

15

FILE

*JUL 16 1920**G. H. Grese*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 15* 19*20*

17

I HEREBY CERTIFY, That I attended deceased from *July 14th*, 19*20*, to *July 15th*, 19*20*, that I last saw him alive on *July 15th*, 19*20*, and that death occurred, on the date stated above, at *7:10 a. m.*

The CAUSE OF DEATH* was as follows:

*Acute Ruptured appendix
spreading purulent peritonitis
hypotensive shock*

CONTRIBUTORY (Secondary)

Cardiac Failure

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *July 14th*Was there an autopsy? *no*What test confirmed diagnosis? *Operation*

(Signed)

J. J. H. H. H.

M. D.

195, 1920 (Address)

University City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

atlantic city N. J.

DATE OF BURIAL

July 17 1920

20 UNDERTAKER

Wm. Cook

ADDRESS

*5022 North**Amc*

CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *27th*)

2-FULL NAME

(a) RESIDENCE. No. *Park Heights & Myler Ave. 27th*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Feb 17 - 1870

7 AGE

50

Years

Months

Days

If LESS than 1 day, hrs. or min.

*"**5**28*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Priest

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Jefferson J. Walsh

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Maryland

12 MAIDEN NAME OF MOTHER

Emma S. Gaudin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md.

PARENTS

14

Informant (Address)

Jefferson J. Walsh Jr. 2725 E. Calvert St

15

Filed

JUL 16 1920 G. H. Grese

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 15 1920

17

I HEREBY CERTIFY, That I attended deceased from *July 15, 1920*, to *July 15, 1920*, that I last saw him alive on *July 15, 1920*, and that death occurred, on the date stated above, at *9 A.M.*

The CAUSE OF DEATH* was as follows:

Uremic Convulsions + Heart Exhaustion

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

at Home

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

urinary

(Signed)

W. D. Wells

M. D.

19 (Address)

Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cemetery

DATE OF BURIAL

7/19 1920

20 UNDERTAKER

Henry W. Mears & Son 805 W. Calvert

HEALTH DEPARTMENT—CITY OF BALTIMORE

244839

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 N. Guil ST.: 4 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 231 N. Guil

(Usual place of abode)

Length of residence in city or town where death occurred

ST.: 4

WARD.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OF RACE C 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) Alice Bauko

6 DATE OF BIRTH (month, day, and year) Jan 1887

7 AGE 33 Years 6 Months 11 Days If LESS than 1 day, hra. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bootblack

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Balt. Md

10 NAME OF FATHER Lewis Bauko

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

PARENTS

14 Informant (Address) 231 N. Guil St. F.

15 JUL 16, 1920 G. H. Grese.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/13/20

17 I HEREBY CERTIFY, That I attended/deceased from

that I last saw h. alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. C. B. B. M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

1631 Broadway

Geo. J. Holland

DATE OF BURIAL

July 16, 1920

ADDRESS

1631 Broadway

2 44840 HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH. 154 44840

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Clarkson ST. 23 WARD)

2-FULL NAME

Charlotte Jannatewitz

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 1608 Clarkson ST. 23 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? 65 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Jannatewitz

6 DATE OF BIRTH (month, day, and year) May 30 1874

7 AGE Years 79 Months 1 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Fred Brauch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Chas. Jannatewitz 1640 Haverhill St.

15 Filed JUL 16 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to July 14, 1920, that I last saw him alive on July 14, 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows: Infirmities of old age

(duration) yrs. mos. 14 ds. CONTRIBUTORY (Secondary) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically (Signed) R. B. Campbell, M. D.

16, 1920 (Address) 1640 Haverhill St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Cemetery July 17 1920

20 UNDERTAKER ADDRESS F. B. Wapner 2236 Fred St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1135 N Monroe ST. 16 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 1135 N Monroe St.; 1 yrs., 4 mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH,

Aug. 4th, 1889
(Month) (Day) (Year)

7-AGE,

30 yrs., mos., ds. If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,
(State or Country)

Adams Co Pa

10-NAME OF FATHER,

Joseph E. Althoff

11-BIRTHPLACE OF FATHER

(State or Country) Adams Co Pa

12-MAIDEN NAME OF MOTHER

Annie E. Crosta

13-BIRTHPLACE OF MOTHER

(State or Country) Gettysburg Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

James H. Walsh

(Address) 1135 N. Monroe St.

15-

JUL 16 1920 G. H. Grese.

Filed..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

October 1919, to July 14 1920,

that I saw her alive on July 14 1920,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs., 2 mos., ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) 1 yrs., 2 mos., ds.

(Signed) Chas. J. Wells M. D.

July 14, 1920 (Address) Arlington Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Coneytown Md July 17, 1920

20-UNDERTAKER ADDRESS

Martin Baker & Sons 1827 N. North

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 Belvedere Ave. East)2-FULL NAME John Darr(a) RESIDENCE. No. 132 Belvedere Ave. East

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

widowed5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofMargaret Darr

6 DATE OF BIRTH (month, day, and year)

Feb 8 - 1851

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.6957

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

black

(b) General nature of industry, business, or establishment in which employed (or employer)

M. S. & V. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Maryland

10 NAME OF FATHER

Nathaniel Darr11 BIRTHPLACE OF FATHER (city or town)
(State or country)md

12 MAIDEN NAME OF MOTHER

Sarah Darr13 BIRTHPLACE OF MOTHER (city or town)
(State or country)md

14

Informant
(Address)J. Palmer Darr
132 E. Belvedere Ave.

15

Filed

JUL 16 1920

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 15 1920

17

HEREBY CERTIFY, That I attended deceased from

July 1, 1920, to July 15, 1920.that I last saw him alive on July 13, 1920.and that death occurred, on the date stated above, at 6:20 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? 733 W. Fayette StDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Fluoroscopic.(Signed) Thomas J. Walker, M. D.19 (Address) Marlborough Apt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral7-17 1920

20 UNDERTAKER

ADDRESS

Thomas J. Walker733 W. Fayette St

TION is very important. See instructions on back of certificates.

Berkenfeld
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *235* St. *3* WARD)

2-FULL NAME

(Residence in Baltimore: No. *235* St. *3* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

F.

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH

*Unknown**1855*

(Month)

(Day)

(Year)

7-AGE

65

yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

House wife

9-BIRTHPLACE,

(State or Country),

Russia

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

*JUL 16 1920**E. H. Grese*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 16, 1920

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*July 15, 1920, to July 15, 1920,*that I saw her alive on *July 15, 1920,*and that death occurred, on the date stated above, at *11:45 a.m.*

The CAUSE OF DEATH* was as follows:

Valvular Lesion of the heart

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *A. G. Friedman* M. D.*July 16, 1920* (Address) *918 E. Fayette*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bethlehem Cemetery July 16, 1920

20-UNDERTAKER

ADDRESS

Joseph Lewis 1411 E. Balto

important. See instructions on back of certificate.

44844 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2538 E Baltimore ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Margaret V. Rudolph

(a) RESIDENCE, NO.

2538 E Balto

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

White

Widowed

5 ~~Single~~ Married, Widowed, Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John J. Rudolph

6 DATE OF BIRTH (month, day, and year)

June 20 1870

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

50

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Wm. J. Schuyler

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margaret Schuyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mrs. Adela Vogt
2538 E Balto St

15

File

JUL 16 1920

G. H. Grese

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 17 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 5 1920 to July 14 1920

that I last saw her alive on July 13 1920

and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Toxaemia & Exhaustion

(duration) yrs. 3 mos. — ds.

CONTRIBUTORY

Carcinoma of Du-

(duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/11/20

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. B. Kelly M. D.

1920 (Address) 66 E. 11th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery

July 17 1920

20 UNDERTAKER

J. Herwig & Co

ADDRESS

2008 Wilman

CAUSE OF DEATH IN plain terms, so that it may be understood by laymen. See instructions on back of certificates.

1044846

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044846

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. James' Hospital*)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mr. John H. Snyder

(a) RESIDENCE. No.

1044 Hartford Ave. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

47 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Mrs. E. H. Snyder*

6 DATE OF BIRTH (month, day, and year)

Nov 1890

7 AGE

Years

Months

Days

LESS than
1 day, ____ hrs.
or ____ min.*47 yrs**do not know*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Carpenter

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*and Benjamin Snyder*

10 NAME OF FATHER

do not know

11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER

do not know

13 BIRTHPLACE OF MOTHER (city or town)

do not know

(State or country)

14

Informant
(Address)*Mrs. E. H. Snyder
1044 Hartford Ave.*

15

Filed

*JUL 16 1920**ROBERT E. [illegible]*

Burial Permit Only

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

7-15-20

17

I HEREBY CERTIFY, That I attended deceased from

7-8-1920, to *7-15-1920*that I last saw him alive on *7-15-1920*and that death occurred, on the date stated above, at *9:30 a.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach(duration) *2* yrs. ____ mos. ____ ds.CONTRIBUTORY
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *Yes* Date of *7-13-20*Was there an autopsy? *No*What test confirmed diagnosis? *Fluoroscope*(Signed) *E. H. Adams*, M. D.19 (Address) *St. Agnes*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral Cemetery**July 17 1920*

20 UNDERTAKER

ADDRESS

*Henry Hoeck, Son**1301 E. Eager St.*

TION is very important. See instructions on back of certificates.

Trentth
HEALTH DEPARTMENT—CITY OF BALTIMORE1044847
CERTIFICATE OF DEATH. +108

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *St. Agnes' Hospital* ST.: *75* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

1 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept. 1888

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*13**9*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ellicott City

10 NAME OF FATHER

Mr. Trentth

11 BIRTHPLACE OF FATHER (city or town) (State or country)

near Ellicott Md. do not know.

12 MAIDEN NAME OF MOTHER

Gertrude Koenig

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

md.

14

Informant (Address)

Informant Trentth Ellicott City Md. R.F.D.

15

*JUL 16 1920**ROBERT E. LEAUTEK Registrar*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 16 - 1920

17

I HEREBY CERTIFY, That I attended deceased from

*July 15th 1920 to July 16 1920*that I last saw her alive on *July 16 1920*and that death occurred, on the date stated above, at *3:15 A.M.*

The CAUSE OF DEATH* was as follows:

General peritonitis

(duration)

yrs.

mos.

4

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

yes Date of July 15

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

C. A. Leuter

M. D.

19

(Address)

St. Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**July 17 1920*

20 UNDERTAKER

Easton Sons

ADDRESS

Ellicott City

CAUSE OF DEATH in plain terms, as far as possible, on back of certificate. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. *AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044848

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1044848

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

1208 N. Central Ave. ST. 10 WARD)

2 FULL NAME

Mary Coffey
1208 N. Central Ave. 60

(Residence in Baltimore: No.

Str.: yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Wid.

6 DATE OF BIRTH

Unknown; 1 (Month) (Day) (Year)

7 AGE

80

yrs. mos. ds. or min.?

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Nurse

OOD

9 BIRTHPLACE (State or country)

Ireland

PARENTS

10 NAME OF FATHER

Harry Dugerty

11 BIRTHPLACE OF FATHER (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Bridget Muller

13 BIRTHPLACE OF MOTHER (State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Bessie Coffey

(Address)

1208 N. Central Ave

15

Filed

JUL 16 1920

ROBERT A. ERAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 14, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 9, 1920, to July 14, 1920

that I saw her alive on July 14, 1920.

and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

Ch. Myocarditis

Duration = 2 years (Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Signed) W. J. Riley (Duration) yrs. mos. ds.

July 12, 1920 (Address) 1659 Bway M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Cathedral

DATE OF BURIAL

July 17, 1920

20 UNDERTAKER

ADDRESS

H. C. Wiedefeld 917 Greenmount Ave

1044849

HEALTH DEPARTMENT CITY OF BALTIMORE

1044849

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Little Sisters of the Poor

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.;

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Jennie Fillingier

(Residence in Baltimore: No.

Little Sisters of the Poor

St.;

yrs.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

Single

6-DATE OF BIRTH,

Apr.

17

1859

(Month)

(Day)

(Year)

7-AGE,

61 yrs. 2 mos. 29 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Baltimore Md.

10-NAME OF FATHER,

John Fillingier

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Mary Fillingier

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Sister Benedict

(Address)

Little Sisters of the Poor

15-

JUL 16 1920

ROBERT E. KRAUTH

Filed

191

Baltimore

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July

16

1920

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I saw him alive on July 14 1920,

and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Dropy

(Signed) J. A. Warner M. D.

July 16, 1920 (Address) 1133 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 2 yrs. 2 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral

July 17, 1920

20-UNDERTAKER

ADDRESS

H. C. Wiedefeld 94 Greenmuhb

important. See instructions on back of certificate.

1044850

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044850

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

607 Wyandale Ave ST.

WARD) 9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Logsdon

(a) RESIDENCE. NO.

607 Wyandale Ave

WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

22 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

HUSBAND of

(or) WIFE of

Widow of Wm H Logsdon

6 DATE OF BIRTH (month, day, and year)

May 20 1830

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

or min.

90 1 25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

James Algie

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Scotland

12 MAIDEN NAME OF MOTHER

Jane Inglis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Mary O. Deigan 607 Wyandale Ave

15

Filed

JUL 16 1920

ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 15 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 23, 1920, to July 15, 1920

that I last saw her alive on July 12, 1920

and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. D. Steenken, M. D.

Address 3949 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Londy Park

July 17 1920

20 UNDERTAKER

ADDRESS

Wm. H. 502 E. Pratt St

TION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044851

HEALTH DEPARTMENT—CITY OF BALTIMORE

Trinsley

1044851

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1674 E. Pratt St. 3 WARD)
2-FULL NAME Mary Ann Trinsley
(Residence in Baltimore: No. 1674 E. Pratt St. 70 yrs., mos. ds.)
REGISTERED No. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female	4-COLOR OR RACE, White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married
6-DATE OF BIRTH,, 1848 (Month) (Day) (Year)		
7-AGE, 172 yrs. mos. ds. If LESS than 1 day, hrs. or min.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Sax Lams		
9-BIRTHPLACE, (State or Country), Germany		
PARENTS.	10-NAME OF FATHER, Frederick Trinsley	
	11-BIRTHPLACE OF FATHER (State or Country), Germany	
	12-MAIDEN NAME OF MOTHER Christina Blecker	
	13-BIRTHPLACE OF MOTHER (State or Country), Germany	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)
Mrs. Julius Nelloig
(Address) 702 N. North St. Ave.

15-
Filed JUL 16 1920
ROBERT B. LEAUTHE
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,
July 15, 1940
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation and that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Septicemia
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Gangrene of foot
(Duration) yrs. mos. ds.
(Signed) J. H. Hughes M. D. (Coroner.)
July 16, 1940 (Address) 1716 E. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,
Lorraine Cemetery July 17, 1940
ADDRESS
H. C. Hughes 1716 E. Pratt St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant
(Address)

15

Filer

JUL 16 1920

ROBERT J. ELAUGHTER
Registrar
Baptist Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 5, 1920, to July 14, 1920,
that I last saw him alive on July 14, 1920,
and that death occurred, on the date stated above, at 2:45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of antrum
General weakness

(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic exam of tissue

(Signed) E. T. Bragley, M. D.

, 19 (Address) 2171 Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Bedford City Va July 17

20 UNDERTAKER

ADDRESS

H. C. Hughes 1711 Broadway

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

106 E. Center

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Young

(a) RESIDENCE. No.

106 E. Center

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 15-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Baltimore
Maryland

10 NAME OF FATHER

George Young

11 BIRTHPLACE OF FATHER (city or town) (State or country)

North Carolina

12 MAIDEN NAME OF MOTHER

Francis Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore
Maryland

14

Informant (Address)

George Young
106 E. Center St.

15

File

JUL 17, 1920

G. H. G.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 16th 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 15, 1920, to July 16, 1920,

that I last saw him alive on July 16, 1920,

and that death occurred, on the date stated above, at 9:30 A. M.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. H. Douglas, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Ct

July 17, 1920

20 UNDERTAKER

ADDRESS

L. H. Brown & Son

108 W. Monty

CAUSE OF DEATH is very important. See instructions on back of certificates.

44854

Grake
HEALTH DEPARTMENT—CITY OF BALTIMORE

44854

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 S Charles ST.: 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Nettie E Grake

(a) RESIDENCE. No. 1718 S Charles ST.: 23 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Frederick T Grake

6 DATE OF BIRTH (month, day, and year)

July 18 1890

7 AGE Years Months Days

29 11 28

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Charles W Hollet

11 BIRTHPLACE OF FATHER (city or town) (State or country)

York Pa

12 MAIDEN NAME OF MOTHER

Anna Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

York Pa

14

Informant (Address)

Frederick T Grake 1718 S Charles St

15

Filed

JUL 17 1920 G. H. Gresham Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1920

17 I HEREBY CERTIFY, That I attended deceased from

June 15 1920 to July 15 1920

that I last saw him alive on July 15 1920

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

CONTRIBUTORY (Secondary) Acute dilatation of heart

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. B. Campbell, M. D.

16 1920 (Address) 1644 Hanover St

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Oliver's Cemetery July 17 1920

20 UNDERTAKER

ADDRESS

Mrs J. E. Evanson 428 S. Calhoun

CAUTION: This certificate is not valid unless filed in the office of the Registrar. See instructions on back of certificate.

244855 HEALTH DEPARTMENT—CITY OF BALTIMORE 244855

81
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 E. Cor Woodbourne Pratt St. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 11 mos. 23 ds. How long in U. S., if of foreign birth? 62 yrs. 11 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 62 Months 11 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

JUL 17 1920

G. H. Grese

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1920

17

I HEREBY CERTIFY, That I attended deceased from

Oct 1918, to July 15, 1920,

that I last saw him alive on July 15, 10 P.M., 1920,

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows: Rupture of

aneurism of aorta - thoracic.

Aneurism of at least 4 years

duration.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted? Don't know

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Fluoroscopic

(Signed) Geo. H. Hopking, M. D.

7/16, 1920 (Address) 5835 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Shirwood P.E. Cemetery (Cockeysville) July 18 1920

20 UNDERTAKER

STEWART & MOWEN COMPANY

(WILLIAM F. WOODEN, Registrar)

ADDRESS

108 W. NORTH AVE.

TION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

244856 HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH.
PLACE OF DEATH Off Davison Chemical Co.
CITY OF BALTIMORE (No. Curtis Bay. ST.: 25 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Albert M. Straughen.
(Residence in Baltimore: No. 2019 Bank Street. St.: yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married.
6-DATE OF BIRTH, March 18th, 1876. (Month) (Day) (Year)
7-AGE, 44 yrs. 3 mos. 27 ds. If LESS than 1 day, hrs. or min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work, Captain of barge. (b) General nature of industry, business, or establishment in which employed (or employer), Mary A. Hooper.
9-BIRTHPLACE, (State or Country), Rock Hall Md.
10-NAME OF FATHER, James L. Straughen.
11-BIRTHPLACE OF FATHER (State or Country), New Jersey.
12-MAIDEN NAME OF MOTHER, Mary V. Kendall.
13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lida Straughen (wife).

(Address) 2019 Bank Street.

15- JUL 17 1920

Filed 191

G. H. Grese

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 15th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.
Accidental fall from a barge.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Otto M. Penkhart (Coroner.) July 16th 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cedar Hill Cemetery July 17, 1920

20-UNDERTAKER ADDRESS

H. Vandevy & Sons 1710 Fleet St

844857 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 333 W. Biddle ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 333 W Biddle St.; 30 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Unknown, 1860.
(Month) (Day) (Year)

7-AGE,

60 yrs.

mos. ds.

If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Cook 021
Private Family9-BIRTHPLACE,
(State or Country),

Md.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER
(State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Rev M. J. Taylor
507 W. Lorraine St.

15-

Filed

JUL 17 1920

191

G. H. Grese.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 22, 1920, to July 12, 1920, that I saw her alive on July 12, 1920, and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
with hemiplegia

(Duration) ... yrs. ... mos. 12 ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed)

Chas. Keller M. D.
July 15, 1920. (Address) 222 W. Monmouth St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Mt. Auburn Cemetery

DATE OF BURIAL.

July 17, 1920

20-UNDERTAKER

John M. Johnson

ADDRESS

1234 E. 11th St.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44858

151844858

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 S Regester ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Maryanna Szarek

(a) RESIDENCE. NO.

511 S Regester ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 16 1916

7 AGE

Years

Months

Days

If LESS than 1 day, 6 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Peter Szarek

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Maryanna Janicki

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Peter Szarek 511 S Regester

15

Filed

JUL 17 1920

G. H. Grosse Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 16 1920

17

I HEREBY CERTIFY, That I attended deceased from July 16, 1920, to July 16, 1920, that I last saw him alive on July 16, 1920,

and that death occurred, on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

Pneumonia (6 mos.)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Ventura, M. D.

19 20 (Address) 1603 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary Cemetery July 17 1920

20 UNDERTAKER

ADDRESS

John M. Weber 1803 Bank

CAUSE OF DEATH is printed in plain terms on back of certificates. See instructions on back of certificates.

244859 HEALTH DEPARTMENT—CITY OF BALTIMORE
 CERTIFICATE OF DEATH. X 169 244859

PLACE OF DEATH
 CITY OF BALTIMORE (No. Port Covington. ST. 25 WARD)
 2-FULL NAME Arthur T. Wood.
 (Residence in Baltimore: No. 32 Seymore Road Tilburry England. yrs., mos. ds.) 15.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single.
 6-DATE OF BIRTH, December 7th, 1905., / (Month) (Day) (Year)

7-AGE, 14 yrs. 7 mos. 8 ds. If LESS than 1 day, hrs. or min. 086

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Deck boy on motor-ship Mississippi. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), England.

PARENTS. 10-NAME OF FATHER, Thomas Wood. 11-BIRTHPLACE OF FATHER (State or Country), England. 12-MAIDEN NAME OF MOTHER, Nellie Best. 13-BIRTHPLACE OF MOTHER (State or Country), England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Thomas Wood (father). (Address) 32 Seymore Road Tilburry England.

15- JUL 17 1920 G. H. Grese. Filed 191. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 15th, 1920, 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry and that said deceased came to his death (Inquest, autopsy or inquiry.) on the day stated above. The CAUSE OF DEATH* was as follows:

Accidentally drowned while in swimming. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) Otto M. Remhardt (Coroner.) July 16th 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence Tilburry England.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Cedar Hill Cem July 17 1920

20-UNDERTAKER, ADDRESS, Joseph B. Coe 3 N. Calosa

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

244860

HEALTH DEPARTMENT—CITY OF BALTIMORE

244860

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. Port Covington.

ST. 25 WARD

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Bertie Condon.

(Residence in Baltimore: No.

29 Church St. Poole England. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White.

5-SINGLE, Single.
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

October 2nd, 1902, 1
(Month) (Day) (Year)

7-AGE.

17 yrs. 9 mos. 13 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Deck boy on motor
(b) General nature of industry, business, or establishment in which employed (or employer) ship Mississippi.9-BIRTHPLACE,
(State or Country),

England.

10-NAME OF FATHER,

Do not know.

11-BIRTHPLACE OF FATHER
(State or Country),

Do not know.

12-MAIDEN NAME OF MOTHER

Ellen-----

13-BIRTHPLACE OF MOTHER
(State or Country),

Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Capt. James T. J. Wylie.

(Address) Captain of Motorship Mississippi.

15-

JUL 17 1920

G. H. Grese.

Filed.....

101.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 15th, 1920, 191...
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry.
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.
(Inquest, au-inquiry and that said deceased came to his death
(Inquest, autopsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally drowned while in swimming.

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner.)

July 16th, 1920. (Address) 1817 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Poole England.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cedar Hill Cem July 17 1920

20-UNDERTAKER

ADDRESS

Joseph Block 1003 N. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly entered on back of certificate. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *912 Ramsey* ST. *21* WORD)2-FULL NAME *Leons Audrey Russell*(Residence in Baltimore: No. *912 Ramsey* St.; yrs. *6* mos. *4* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female*4-COLOR OR RACE, *white*5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)6-DATE OF BIRTH, *Jan 12th 1920*

(Month)

(Day)

(Year)

7-AGE, *6 yrs. 4 mos. 4 ds.*

yrs. mos. ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... *none*
(b) General nature of industry, business, or establishment in which employed (or employer)...9-BIRTHPLACE, (State or Country), *Baltimore*10-NAME OF FATHER, *James Oscar Russell*11-BIRTHPLACE OF FATHER (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER *Matthias Francis Bunnell*13-BIRTHPLACE OF MOTHER (State or Country), *Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. J. Russell*(Address) *912 Ramsey St.*

15-

Filed *JUL 17 1920**G. H. Grese*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 16th 1920*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 12th 1920*, to *July 16th 1920*.that I saw him alive on *July 16th 1920*,and that death occurred, on the date stated above, at *5:45 P.M.*

The CAUSE OF DEATH* was as follows:

Exhaustion(Duration) ... yrs. ... mos. ... ds. *1*CONTRIBUTORY (Secondary) *Enterocolitis*(Duration) ... yrs. ... mos. ... ds. *10*(Signed) *J. P. Bunnell* M. D.*7/16/20* 191... (Address) *654 Columbus St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cedar Hill Cem*DATE OF BURIAL, *July 17th 1920*20-UNDERTAKER *John J. Kavanagh & Son*ADDRESS *301 N. Hollen St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3285 Smallerwood ST.: 20 WARD)2-FULL NAME William Post

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 3285 Smallerwood ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Post6 DATE OF BIRTH (month, day, and year) Sept 11 - 18497 AGE Years Months Days If LESS than 1 day, hrs. or min.
71 9 6 — — —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hill & Curran9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER William Post11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

PARENTS

14 Informant Caroline Post
(Address) 3285 Smallerwood St

15

Filed

JUL 17 1920G. H. Grese.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 192017 I HEREBY CERTIFY, That I attended deceased from July 10 1920 to July 16 1920, that I last saw him alive on July 16 1920, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular Heart Disease(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) Compensatory failure yrs. mos. ds. 2

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry J. Sussman

M. D.

July 16 1920 (Address) 76 E 7 West Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Cemetery

DATE OF BURIAL

July 19, 1920

20 UNDERTAKER

G. W. DillADDRESS 3109Fredk. & Co.

TION is very important. See instructions on back of certificates.

844864 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Jenkins

(a) RESIDENCE. NO. 726 Curtis Court

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

Colored

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ray Assorter

(b) General nature of industry, business, or establishment in which employed (or employer)

Ray Assorter

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country) born in Baltimore

10 NAME OF FATHER William Jenkins

11 BIRTHPLACE OF FATHER (city or town) Frederick
(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Reason

13 BIRTHPLACE OF MOTHER (city or town) Kent Co.,
(State or country) Md.

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed JUL 17 1920 G. H. Grese,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1920

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1920 to July 15, 1920, that I last saw him alive on July 15, 1920, and that death occurred, on the date stated above, at 5:05 P. m. The CAUSE OF DEATH* was as follows:

Septic arthritis

(duration) 5 yrs. 45 mos. 45 ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 14 mos. 14 ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death? NO Date of

Was there an autopsy? none as yet

What test confirmed diagnosis?

(Signed) J. A. Holden, M. D.

7/16/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Int. Grav. Cemetery July 1920

20 UNDERTAKER

Mrs. R. A. Elliott

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

8 44865

2 44865

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

South Balto. Genl. Hospital. 102

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 14 WARD)

2-FULL NAME

Frank Williams

(a) RESIDENCE. NO.

1604 Druid Hill Ave.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Life yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Cornelia Williams 1883

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook or 1

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Odean Williams Md.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Sarah Gump Md.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Cornelia Williams 1604 Druid Hill Ave. G. H. Grese.

15

Filed

JUL 17 1920

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 13 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 1st 1920, to July 13, 1920.

that I last saw him alive on July 13, 1920.

and that death occurred, on the date stated above, at 8 p.m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer (ruptured)

CONTRIBUTORY (Secondary)

(duration)

3 yrs.

mos.

ds.

(duration)

yrs.

mos.

15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

yes Date of July 14/20

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Howard L. Tolson M. D.

, 19

(Address)

1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn Cem.

July 19 1920

20 UNDERTAKER

Samuel Hensley

ADDRESS

1213 Light St

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Chester(a) RESIDENCE. No. 1111 N. Sarah Ann St. ST.: 18 WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown6 DATE OF BIRTH (month, day, and year) 18827 AGE Years Months Days If LESS than 1 day, hrs. or min. 38

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia (State or country)10 NAME OF FATHER Banks W. Bray11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)12 MAIDEN NAME OF MOTHER Fannie Prary13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)14 Informant Hospital Records (Address) New City Hospital15 File JUL 17 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 192017 I HEREBY CERTIFY, That I attended deceased from July 8, 1920 to July 15, 1920 that I last saw him alive on July 15, 1920 and that death occurred, on the date stated above, at 3:30 P.m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

uterine fibroids (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Autopsy(Signed) W. H. Brown, M. D.7/16/20 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Ambrose July 18 1920

20 UNDERTAKER

Samuel Thomas ADDRESS 578 Middle

TUTION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *2nd St. near Jackson St. Brooklyn 25* REGISTERED No. C _____
 CITY OF BALTIMORE: (No. *25* ST.; *WARD*) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 2-FULL NAME *Hilda Bretta Williams*
 (Residence in Baltimore: No. *Above address* St.; *1* yrs., *6* mos., *10* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *M.* 4-COLOR OR RACE, *C.* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*
 6-DATE OF BIRTH, *January 6th, 1919*
 (Month) (Day) (Year)
 7-AGE, *1* yrs., *6* mos., *10* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *infant*
 (b) General nature of industry, business, or establishment in which employed (or employer) *ooo*

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Benton C. Williams

11-BIRTHPLACE OF FATHER (State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Rosetta Gross

13-BIRTHPLACE OF MOTHER (State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Benton C. Williams*(Address) *Brooklyn Ma*

15-

Filed

JUL 17 1920

191

G. H. Grese.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 16th, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Jan 1st 1920*, to *July 16 1920*, that I saw her alive on *July 13 1920*, and that death occurred, on the date stated above, at *8 p. m.*

The CAUSE OF DEATH* was as follows:

Meningitis, preceded by
pyelitis
 (Duration) *6* yrs., *6* mos., *10* ds.

CONTRIBUTORY *none other than above*
(Secondary)(Duration) *6* yrs., *6* mos., *10* ds.(Signed) *Geo. S. D. Ders* M. D.*July 17, 1920* (Address) *211 Church St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs., *6* mos., *10* ds. In the State *1* yrs., *6* mos., *10* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Williams Home Cemetery AAC

DATE OF BURIAL,

JUL 18 1920

20-UNDERTAKER

JOHN F. DENNY

ADDRESS

715 LIGHT ST.

244868

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 244868

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3507 E. Balto.

ST.: 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary E. V. Ison

(a) RESIDENCE. No.

3507 E. Balto

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

William H. Ison

6 DATE OF BIRTH (month, day, and year)

Aug. 9-1872

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.

or min.

47

11

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Balto. City

10 NAME OF FATHER

Henry Wise

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Mary Lyons

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Va.

14

Informant

(Address)

William H. Ison
3507 E. Balto. St.

15

Filed

, 19

G. H. Grese

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 16 1920

17

I HEREBY CERTIFY, That I attended deceased from

about April 1, 1920, to July 16, 1920,

that I last saw him alive on July 16, 1920,

and that death occurred, on the date stated above, at 1:40 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No

Date of

Was there an autopsy? No

What test confirmed diagnosis?

T. B. in Sputum

(Signed)

Geo. L. McArthur, M. D.

, 19 (Address)

6 N. Chesapeake

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Petersworth Church
S. Lourester Co. Va.

July 17 1920

20 UNDERTAKER

ADDRESS

Wm. E. Black 927 N. Broadway

CAUSE OF DEATH IN PAINTED TERMS, SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

A 44869

HEALTH DEPARTMENT—CITY OF BALTIMORE

A 44869

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *1100*)ST.: *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs. *9* mos. *22* ds.

How long in U. S., if of foreign birth?

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*White*5 Single, Married, Widowed,
or Divorced (write the word)*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 9, 1918

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*1**9**22*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*None*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Balti.
Md.*

10 NAME OF FATHER

*Michael Molchanoff*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Russia*

12 MAIDEN NAME OF MOTHER

*Catherine*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Russia*

14

Informant
(Address)*Michael Molchanoff
1605 Madison Ave*

15

Filed

*JUL 17 1920**C. H. Grese, Registrar*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1920

17

I HEREBY CERTIFY, That I attended deceased from

1/16, 19*20*, to*7/17*, 19*20*.that I last saw him alive on *7/17*, 19*20*.and that death occurred, on the date stated above, at *12:30 a.m.*

The CAUSE OF DEATH* was as follows:

*Multiple Pulmonary
Emboli*(duration) yrs. mos. *4* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *Yes* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Samuel D. Roberts, M.D.**7/17, 1920* (Address) *Mary Hospital**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park Cem**July 17 1920*

20 UNDERTAKER

John O. Mitchell

ADDRESS

12017 Zay...

CAUSE OF DEATH is very important. See instructions on back of certificates.

D44870

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ 1044870

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 N. Biddle ST.; 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1056 Argyle Ave.

(Usual place of abode)

ST.

WARD. 17

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

19

17

I HEREBY CERTIFY, That I attended deceased from

July 2, 1920, to July 16, 1920,

that I last saw him alive on July 16, 1920,

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Intestinal hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Thompson, M. D.

19 (Address) 101 90th Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mifford Sta Va July 19 1920

20 UNDERTAKER

ADDRESS

Samuel T. Temple, 578 N Biddle

TION is very important. See instructions on back of certificates.

141794

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 1044871

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Harold Baker

(a) RESIDENCE. No. *Hertford N.C.*

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

X

6 DATE OF BIRTH (month, day, and year)

Aug 21 - 1911

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

9

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

North Carolina

10 NAME OF FATHER

James Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country)

North Carolina

12 MAIDEN NAME OF MOTHER

Cre Goodwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

North Carolina

14

Informant (Address)

7777 Records

15

Filled

19

Registrar

JUL 18 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 17 - 1920

17

I HEREBY CERTIFY, That I attended deceased from

June 28, 1920 to July 17, 1920

that I last saw him alive on *July 17, 1920*

and that death occurred, on the date stated above, at *3 P. m.*

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(duration) yrs. *2* mos. ds.

CONTRIBUTORY (Secondary)

none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

home

Did an operation precede death? No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

clinical signs

(Signed) *Harold L. Staggins M. D.*

7/17/20 Address

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hertford N.C.

July 18 1920

20 UNDERTAKER

ADDRESS

Wm. C. Black 927 N. Broadway

CAUSE OF DEATH IN PLAIN ENGLISH. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *44872*)

2-FULL NAME

Mrs Catherine Rodgers

(a) RESIDENCE. NO.

Bay Ridge Road 4 Slab

Length of residence in city or town where death occurred

yrs.

mos.

16 ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD)

WARD.

(If nonresident give city or town and State)

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Widow of

6 DATE OF BIRTH (month, day, and year)

1853

7 AGE

Years

Months

Days

67

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

John Kahanagel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Turlock

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

University Hospital Records

15

Filed

*JUL 18 1920**ROBERT E. FRANKLIN Registrar*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 17 1920

17

I HEREBY CERTIFY, That I attended deceased from

*July 1st 1920 to July 17 1920*that I last saw him alive on *July 17 1920*and that death occurred, on the date stated above, at *5:00 P.M.*

The CAUSE OF DEATH* was as follows:

Inoperable carcinoma of the bladder

CONTRIBUTORY (Secondary)

Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *7-3-1920*Was there an autopsy? *No*What test confirmed diagnosis? *Operation*

(Signed)

W. J. 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Green

DATE OF BURIAL

July 20 1920

20 UNDERTAKER

Taylor & Sons

ADDRESS

Green

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44873

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044873

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 500 E Barry ST. 24 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 500 E Barry ST. 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. 3 mos. 2 ds. How long in U. S. if of foreign birth? 1 yrs. 3 mos. 2 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10 1919

7 AGE Years 1 Months 3 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

10 NAME OF FATHER Mr. J. J. J. J.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Penelope Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) 500 E Barry St.

15 Filled JUL 18 1920 ROBERT A. FRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1920

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1920, to July 17, 1920, that I last saw him alive on July 17, 1920, and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signed) R. P. Hamner, M. D. (Address) 1644 Hancock

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

bedas Hill Cem 7/18 1920

20 UNDERTAKER ADDRESS

J. Hew McLeary 130 E. Fort

D44874 HEALTH DEPARTMENT—CITY OF BALTIMORE

1044874

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

2216 Linden Ave

Sarah Lee

2216 Linden Ave

ST. 13 WARD

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country)

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUL 18 1920

ROBERT E. TRAUTER

Baltimore City Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry,

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Gallopel disease

Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. H. M. D.

(Address) 7632 Polk St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Auburn Cemetery July 17, 1920

20-UNDERTAKER

ADDRESS

Relief B. Pye 102 E. Mount Vernon

CAUSE OF DEATH in plain terms, so that it may be properly entered. Exact statement of cause of death is important. See instructions on back of certificate.

1044875

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044875

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Off Kirby's Park
CITY OF BALTIMORE (No. Spring Gardens. ST. 25 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Louis Fried.
(Residence in Baltimore: No. 1012 Simpson St. New York. St.: yrs. -- mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single. (Write the word.)
6-DATE OF BIRTH, Do not know. /
(Month) (Day) (Year)
7-AGE, 21 yrs. -- mos. -- ds. If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Manager of show.
(b) General nature of industry, business, or establishment in which employed (or employer). 086

9-BIRTHPLACE, (State or Country). Austria, Hungary.

10-NAME OF FATHER, Herman Fried.
11-BIRTHPLACE OF FATHER (State or Country). Austria, Hungary.
12-MAIDEN NAME OF MOTHER, Ester Levy.
13-BIRTHPLACE OF MOTHER (State or Country). Austria, Hungary.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry Fried. (brother)
(Address) 402 E. 79th St. New York.

15- JUL 18 1920 ROBERT F. ERAUTER
Filed 191. BUREAU OF VITALS

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 16th, 1920, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry.
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Accidentally Drowned while in swimming.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ...
(Duration) yrs. mos. ds.
(Signed) Otto M. Reinhardt M. D. (Coroner)
July 16, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence New York City.

19-PLACE OF BURIAL OR REMOVAL, New York City DATE OF BURIAL, JUL 18 1920

20-UNDERTAKER, JOHN F. DENNY ADDRESS, 716 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

1044876

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044876

CERTIFICATE OF DEATH

1-PLACE OF DEATH

South Balt. Genl. Hosp

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 17 WARD)

2-FULL NAME

Henry Parker

(a) RESIDENCE. NO.

809 10 Franklin

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

12 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

1879

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

41

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

North Carolina

10 NAME OF FATHER

John Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N.C.

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

unknown

14

Informant (Address)

Mamie Parker

809 West Franklin

15

Filed

19

JUL 18 1920

ROBERT E. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 15 1920

17

I HEREBY CERTIFY, That I attended deceased from July 15, 1920, to July 15, 1920, that I last saw him alive on July 15, 1920,

and that death occurred, on the date stated above, at 11:45 p.m.

The CAUSE OF DEATH* was as follows:

acute intestinal obstruction
Genl. Peritonitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

yes

Date of 7-15-20

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Howard R. Tolson, M. D.

, 19

(Address)

1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Joseph A. Farrell

ADDRESS

2319 1/2 Union

1044877 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 W. Larrale ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Anna Nowlin

(a) RESIDENCE. NO. 1714 W. Larrale ST. 16 WARD.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 28 yrs. 16 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1 1892

7 AGE Years 28 Months 16 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Peyton R. Nowlin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Texas

12 MAIDEN NAME OF MOTHER

Jan Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

W. Va

14

Informant (Address)

Mrs. Jan Nowlin
1714 W. Larrale St.

15

JUL 18 1920

ROBERT H. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to July 17, 1920, that I last saw her alive on July 16, 1920, and that death occurred, on the date stated above, at 7:20 a.m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(duration) yrs. mos. ds. unknown

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Walter A. Coy, M. D.

19 (Address) 571 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lorraine Cem.

July 19 1920

20 UNDERTAKER

ADDRESS

Harry W. Ehlen W. North

10 44878 HEALTH DEPARTMENT—CITY OF BALTIMORE

1044878

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2046 Linden Ave. 13

WARD)

2-FULL NAME

Alice Schonfarber

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

2046 Linden Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., If of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 23/1863

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

37

2

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Saleslady. 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Gerson Schonfarber

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Betty Mescher

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

The R. Eytens 2046 Linden

15

Filed

JUL 18 1920

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 16 1920

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 1920, to July 16, 1920,

that I last saw him alive on July 16, 1920,

and that death occurred, on the date stated above, at 7:15 p. m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

No

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed) J. Frederick Lutz, M. D.

7/17, 1920 (Address) 2046 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Chick Shalom

July 18 1920

20 UNDERTAKER

Harold Sondheim

ADDRESS

1184 KENYON

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

10.44879 *Neolin Kaster* HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 10.44879
X 175-004

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *19 Josp Hospital* ST. *5* WARD) REGISTERED NO. C
2-FULL NAME *Neolin Kaster* (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(Residence in Baltimore: No. *1309 S Lexington* St. *Life* yrs. *8* mos. *8* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
6-DATE OF BIRTH, *Feb 16, 1914* (Month) (Day) (Year)
7-AGE, *6* yrs. *6* mos. *8* ds. If LESS than 1 day, ... hrs. or ... min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country), *Chila P.I.*
10-NAME OF FATHER, *Wolf Kaster*
11-BIRTHPLACE OF FATHER, (State or Country), *Austria*
12-MAIDEN NAME OF MOTHER, *Lena Cohen*
13-BIRTHPLACE OF MOTHER, (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Henry*
(Address) *1411 E. Balt.*

15- *JUL 18 1920* *ROBERT B. KRAUTER*
Filed *101* *Bureau of Registration*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 16, 1920* (Month) (Day) (Year)
17-I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)
I find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Pneumonia, heart system car
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Signed) *Wm. J. ...* (Coroner) M. D.
(Address) *...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence *Chicago P.I.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *Hehren Heeringburg July 18, 1920*

20-UNDERTAKER, ADDRESS *Jack Lewis 1411 E. Balt.*

1044880

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044880

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 18)

2-FULL NAME

(Residence in Baltimore: No. 1028 Hollins St.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employed).9-BIRTHPLACE,
(State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

FILED

JUL 18 1920

ID1

ROBERT E. KRAUTH

Baptist Church Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

Thereon and from the evidence obtained by said Inquest, autopsy or inquiry, I find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH was as follows:Traumatic
Septic Pneumonia
Duration yrs. mos. ds.
CONTRIBUTORY Cause by force
(Secondary)
(Signed) Geo. Edmund Gladis M. D.
7/17/20 (Address) 1436 Bway

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

1044881

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044881

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3024 E. Pratt* ST.: *1* WARD)

2-FULL NAME

Anna Sporny

(a) RESIDENCE. NO.

3024 E. Pratt

(Usual place of abode)

Length of residence in city or town where death occurred *57* yrs. mos. ds.

ST.

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? *57* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced, HUSBAND or (or) WIFE of

Joseph Sporny

6 DATE OF BIRTH (month, day, and year)

May 13, 1849

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

71

2

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Wm 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Joseph Sporny 3024 E. Pratt

15 Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 16, 1930

17

I HEREBY CERTIFY, That I attended deceased from *July 3, 1930* to *July 16, 1930* that I last saw *her* alive on *July 15, 1930* and that death occurred, on the date stated above, at *9:20 A. M.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Breasts and Stomach

(duration) *1* yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary Edema (duration) *2* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Edward J. Ross* M. D.

7/16/30 Address *413 N. Washington*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary

July 19, 1930

20 UNDERTAKER

Wendell Wyfel & Son

ADDRESS *37 S. Main*

See instructions on back of certificates.

1044882. HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 8 Eden

ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 314 8 Eden

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 1/2 yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb. 17/1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

10 NAME OF FATHER John Marshowsky

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia Poland

12 MAIDEN NAME OF MOTHER Helen Selinsky

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland

14

Informant (Address)

John Marshowsky 314 8 Eden

15

Filed

19

ROBERT E. KRAUTH

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 17 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 12, 1920, to July 17, 1920,

that I last saw him alive on July 16, 1920,

and that death occurred, on the date stated above, at 7:00 m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Colitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed)

J. P. K.

M. D.

July 19, 1920 (Address)

2120 E. Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mary's - Maple Rd.

July 19 1920

20 UNDERTAKER

ADDRESS

Wendell W. Appelton

278 W. 1st St.

CAUSE OF DEATH OR PLACE OF DEATH is very important. See instructions on back of certificates.

N. B.—Every statement of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044883

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044883

CERTIFICATE OF DEATH

X 104 7

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

1618 E Madison St.
Bernell Ferguson
1618 E Madison St.

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE Colored 5-SINGLE, Married, Widowed, or Divorced (Write the word) Single

6-DATE OF BIRTH January 13, 1920 (Month) (Day) (Year)

7-AGE 6 yrs. 3 mos. 3 ds. or min.?

8-OCCUPATION Infant 000

9-BIRTHPLACE (State or country) New York City

10-NAME OF FATHER Carl F. Ferguson

11-BIRTHPLACE OF FATHER (State or country) Mexico

12-MAIDEN NAME OF MOTHER Ruth Williams

13-BIRTHPLACE OF MOTHER (State or country) Balt. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Magnolia Williams (Address) 1618 E Madison St.

15. JUL 18 1920 ROBERT E. KAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 16, 1920 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 2, 1920, to July 16, 1920, that I saw him live on July 15, 1920, and that death occurred, on the date stated above, at 11:20 a.m. The CAUSE OF DEATH* was as follows:

Gastro-enteritis

Contributory (SECONDARY) Exhaustion (Duration) yrs. mos. 14 ds.

Signed, P. E. Kelly M. D. July 17, 1920 (Address) 820 E. Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) 3 weeks

At place of death, yrs. mos. ds. State, yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence New York City

19-PLACE OF BURIAL OR REMOVAL Not Buried July 19, 1920

20-UNDERTAKER Mrs. G. S. Locks 1302 Jeffers

1044884

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044884

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Milliman ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1608 Milliman St.; 6 yrs., 6 mos., 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Caucasian

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH

January 2, 1920
(Month) (Day) (Year)

7-AGE

6 yrs., 6 mos., 13 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

no 000

9-BIRTHPLACE.
(State or Country),

Balto, Md.

10-NAME OF FATHER,

Jas. H. Pinkney

11-BIRTHPLACE OF FATHER
(State or Country),

Balto

12-MAIDEN NAME OF MOTHER

Madeline Craig

13-BIRTHPLACE OF MOTHER
(State or Country),

Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

JUL 18 1920

BORIS B. EBAUTER

Filed

191

BUREAU

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

July 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 6, 1920, to July 15, 1920, that I saw him alive on July 15, 1920, and that death occurred, on the date stated above, at 4:20 a.m. The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. S. Sage M. D.

July 17, 1920 (Address) 708 1/2 N. E. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Mt. Zion Cem.

July 18, 1920

20-UNDERTAKER

ADDRESS

J. G. Lock's

1302 Jefferson

important. See instructions on back of certificate.

1044885- HEALTH DEPARTMENT—CITY OF BALTIMORE 1044885-

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1538 Clement ST., 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1538 Clement St.; 1 yrs., 11 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

July 13, 1918 (Month) (Day) (Year)

7-AGE,

1 yrs., 11 mos., 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... None (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Frank Wojciechowski

11-BIRTHPLACE OF FATHER (State or Country),

Poland

12-MAIDEN NAME OF MOTHER

Frances Lowicki

13-BIRTHPLACE OF MOTHER (State or Country),

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Wojciechowski

(Address) 1538 Clement

15-

Filed

JUL 18 1920

ROBERT B. SPATER

Baltimore Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 17, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 16, 1920, to July 17, 1920, that I saw her alive on July 16, 1920, and that death occurred, on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Gastro-Intestinal Intoxication

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acidosis (Duration) yrs. mos. ds.

(Signed) Nathan W. H. M. D.

July 17, 1920 (Address) 118 St. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

July 19, 1920

20-UNDERTAKER

William Fialkowski 1164 Eastern Aves

1044886

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044886

1-PLACE OF DEATH

South Baltimore Genl Hosp

REGISTERED NO.

CITY OF BALTIMORE: (No.

12135 Light

ST.:

WARD) 2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Alexandra Kuczyńska

(a) RESIDENCE. NO.

4075 Chapel

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

13 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

13 yrs.

0

mos.

0

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

James Kuczyńska

6 DATE OF BIRTH (month, day, and year)

Unknown 1890

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

30

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER

Joseph. Wozniak

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Stanislaw. Kuczyński 407 S. Chapel St

15

Filed

19

BRIEF FORM 10 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 16 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 14, 1920, to July 16, 1920.

That I last saw her alive on July 15, 1920.

and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Cellulitis of face and neck

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death? Yes Date of 7-14-20

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard L. Tolson, M. D.

7/16, 1920 (Address) 1213 Light St

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary

7/19 1920

20 UNDERTAKER

William Halkowski 1618 Eastern Ave

CASE OF DEATH IN BALTIMORE. See instructions on back of certificates.

1044887 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044887

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 GUYEN ST.; 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 704 Guyen St.

St.; 67 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH.

....., 1853
(Month) (Day) (Year)

7-AGE.

67 yrs., mos., ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

Salesman 066

9-BIRTHPLACE,

(State or Country),

Baltimore Md

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- JUL 18 1920 ROBERT A. LAUTER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

....., 1940.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

....., 1920, to 1920,

that I saw him alive on 1920,

and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

important. See instructions on back of certificate.

1044888

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044888

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 575 W. Preston ST. 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 575 W. Preston St. 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH,

July 1904
(Month) (Day) (Year)

7-AGE,

16

yrs. mos. ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

James Morton

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore Md

12-MAIDEN NAME OF MOTHER

Etta Bracco

13-BIRTHPLACE OF MOTHER
(State or Country),

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Etta Bracco(Address) 575 W. Preston St

15-

Filed

JUL 18 1920

191

ROBERT A. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 17, 1920
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 8th 1920, to July 17 1920, that I saw her alive on July 16- 1920, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed)

Chas. S. Keller M. D.
July 17, 1920 (Address) 422 W. W. W. W.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel Hill

DATE OF BURIAL,

July 21 1920

20-UNDERTAKER

James L. Lusk

ADDRESS

578 W. Biddle

Important. See instructions on back of certificate.

1044889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1044889
28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital

ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank ^{Lin P.} Fuller

(a) RESIDENCE. No. 902 Harford Ave.

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 67

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER John B. Fuller

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Nixon

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md. (State or country)

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1920, to July 16, 1920, that I last saw him alive on July 16, 1920, and that death occurred, on the date stated above, at 11:30 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy (Signed) Lawrence Giff. M. D.

7/17/20 Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Trinity Church

7/19 1920

20 UNDERTAKER

Wm Cook

ADDRESS

502 E. North

tion is very important. See instructions on back of certificates.

JUL 18 1920

1044890 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City HospitalST.: 3

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Dictiker(a) RESIDENCE. No. 918 E. Lombard St.

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 1872

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.48

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.10 NAME OF FATHER John Boltz11 BIRTHPLACE OF FATHER (city or town) Baltimore,
(State or country) Md.12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Md.14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16, 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 8, 1920, to July 16, 1920.that I last saw her alive on July 16, 1920.and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Secondary anemia +
Cachexia (duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?unknownDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? gross sections(Signed) J. G. Holden, M. D.7/17/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Catholic

20 UNDERTAKER

Wm Coor/6

DATE OF BURIAL

7/19 1920

ADDRESS

5028 North

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4508 Maine Ave ST.;

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Coale(a) RESIDENCE. No. 4508 Maine Ave ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city, or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

ROBERT A. FRANKLIN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1920

17

I HEREBY CERTIFY, That I attended deceased from

April 11, 1920, to July 16, 1920,

that I last saw her alive on July 16, 1920,

and that death occurred, on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (W. to Coma 7 days) (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) J. H. Kelley, M. D.

1/18 1920 (Address) 3549 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Balto Cem. July 19/20

20 UNDERTAKER

ADDRESS

Wm Cook & Son E. T. H. H. H.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

1044892

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044892
28-010

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2012 W. Fayette

ST. 20

WARD)

REGISTERED NO. C

2-FULL NAME

Heffenger P. Foxwell

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2012 W. Fayette

St. 32 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male	4-COLOR OR RACE. white	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married
6-DATE OF BIRTH. Aug 10, 1878 (Month) (Day) (Year)		
7-AGE. 41 yrs. 10 mos. 28 ds.		If LESS than 1 day, ... hrs. or ... min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Machinist 831 Sewing machines		

9-BIRTHPLACE. (State or Country).	10-NAME OF FATHER.
St Mary's Co. Md.	Charles Foxwell
11-BIRTHPLACE OF FATHER. (State or Country).	12-MAIDEN NAME OF MOTHER.
Md.	Annie Adams
13-BIRTHPLACE OF MOTHER. (State or Country).	
W. Va.	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

JUL 18 1920

ROBERT B. KRAUTER
BALTIMORE REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 16, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
Oct 7 1919, to July 16 1920,
that I saw him alive on July 15 1920,
and that death occurred, on the date stated above, at 6:54 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary, & general
tuberculosis

(Duration) 1 yrs. 9 mos. 11 ds.

CONTRIBUTORY.
(Secondary)

(Duration) 24 mos. 24 ds.

(Signed) H. E. Kniff M. D.

July 16, 1920. (Address) 1012 W. Fayette

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

1844893

HEALTH DEPARTMENT—CITY OF BALTIMORE

1844893

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
- (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That

remains described above, held an

thereon and from the evidence obtained by said

and that said deceased came to death

topsy or inquiry.)

on the day stated above.

THE CAUSE OF DEATH* and as follows:

Internal Hemorrhage

Rupture of Liver

(Duration) yrs. mos. ds.

CONTRIBUTING (Secondary)

(Duration) yrs. mos. ds.

Signed

(Coroner.)

7/16/1920 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDE.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Haly Rodary July 19, 1920

UNDERTAKER

John M. Weber 1803 Bank St

Important. See instructions on back of certificate.

1044894

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044894

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3414 Toome

ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William W. Fester

(a) RESIDENCE, No. 3414 Toome

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Rosa E. Fester

6 DATE OF BIRTH (month, day, and year) July 14-1874

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
46 - 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Conductor 073

Perma R-R

9 BIRTHPLACE (city or town) (State or country)

Perma, Md.

10 NAME OF FATHER Wm. Fester

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Perma

12 MAIDEN NAME OF MOTHER Rose Coker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Perma

14 Informant Rosa E. Fester
(Address) 3414 Toome St.

15 Filed

JUL 18 1920

ROBERT E. LAUTER
Registrar
BRIAN P. CLARK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1920, to July 16, 1920, that I last saw him alive on July 16, 1920, and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocarditis (Chronic)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. M. Avey, M. D.

6/18, 1920 (Address) 839 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oaklawn Cemetery

July 19 1920

20 UNDERTAKER

Zirkler + Zirkler

ADDRESS

1739 E. Cager

TUTION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3241 ElliottST.: 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara A. Mitchell(a) RESIDENCE, No. 3241 Elliott
(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs.

mos.

ds. How long in U. S., if of foreign birth? 78 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

~~HUSBAND~~
(or) WIFE ofJohn Mitchell6 DATE OF BIRTH (month, day, and year) May 3-18407 AGE Years 80 Months 2 Days 14 If LESS than 1 day, hrs. — or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Andrew Hennig11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Margaret Wegner13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany14 Informant John Mitchell
(Address) 3241 Elliott St.

15 JUL 18 1920

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 19 2017 I HEREBY CERTIFY, That I attended deceased from 6/25/20, 19 20, to 7/16/20, 19 20.that I last saw her alive on 7/16/20, 19 20.and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis Paralysis
(Signed) J. H. Garrell M. D.19 Address 633 - 5 - 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Homicidal, or Suicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore CemeteryJuly 19 1920

20 UNDERTAKER

Girkler + Girkler

ADDRESS

1789 E. Page

TION is very important. See instructions on back of certificates.

1044896

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044896

CERTIFICATE OF DEATH.

14

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johna Hopkins Hosp* ST.: *8* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Joseph Fowler

(a) RESIDENCE. NO.

2436 E Chase St. ST.

WARD.

(Usual place of abode)
Length of residence in city or town where death occurred *2 yrs* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

March 27-1920

7 AGE

Years

3

Months

19

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Frank Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

E. Hanahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Hospital Record J. H. H.

15

Filed

JUL 18 1920

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 16 1920

17

I HEREBY CERTIFY, That I attended deceased from

*July 8, 1920, to July 16, 1920,*that I last saw him alive on *July 16, 1920,*and that death occurred, on the date stated above, at *11:30 p. m.*

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Stool Culture*(Signed) *Harold L. Higgins M. D.*7/17, 1920 Address *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Our Cathedral Cen**July 19 1920*

20 UNDERTAKER

ADDRESS

*Mrs L. Miller 2334 Jefferson**St. Louis*

TION is very important. See instructions on back of certificates.

Block.
HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 1044897104
CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 4017 Eastern Ave. 26 ST.; 104 WARD) REGISTERED NO. C
2-FULL NAME Beatrice Bloch
(Residence in Baltimore: No. 4017 Eastern Ave. St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
4-COLOR OR RACE. White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married
6-DATE OF BIRTH. March 7, 1920
(Month) (Day) (Year)

7-AGE. 4 yrs., 1 mos., 1 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Shied food
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Balco, Md.

PARENTS.
10-NAME OF FATHER. Abraham Bloch
11-BIRTHPLACE OF FATHER (State or Country). Balco, Md.
12-MAIDEN NAME OF MOTHER. Sarah Abrams
13-BIRTHPLACE OF MOTHER (State or Country). New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Abraham Bloch
(Address) 4017 Eastern Ave.

15- JUL 18 1920
Filed..... 191..... ROBERT B. KRAUTER
Bureau Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 18, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1920, to July 15, 1920, that I saw her alive on July 15, 1920, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis
(Duration) yrs. 0 mos. ds.

CONTRIBUTORY (Secondary)

(Signed) A. G. Friedman, M. D.
7/18, 1920 (Address) 918 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Louis Washington Rd. July 18, 1920

20-UNDERTAKER ADDRESS

Jack Lewis, 14112 Balco

1044898

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044898

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 N. Myrtle ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur H. Collins(a) RESIDENCE. NO. 711 N. Myrtle

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofSarah F. Collins6 DATE OF BIRTH (month, day, and year) Feb 29, 1864

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.564

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Porter 090

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Murray Bldg.9 BIRTHPLACE (city or town) Ind.
(State or country)10 NAME OF FATHER Isaac Collins

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ind.12 MAIDEN NAME OF MOTHER Elizabeth Hach

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14

Informant
(Address)Sarah F. Collins
711 N. Myrtle

15

Filed

JUL 18 1920

ROBERT B. ELAINTER
Registrar

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1920

17

I HEREBY CERTIFY, That I attended deceased from

July 1, 1920 to July 16, 1920
that I last saw him alive on July 15, 1920and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage &
(Paralysis of left side)

(duration) yrs. mos. ds.

CONTRIBUTORY Chronic Intestinal Nephritis
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Urinary Analysis & X-ray

(Signed)

John E. Hough

M. D.

717, 1920 (Address)

711 N. Myrtle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. VernonJuly 19 1920

20 UNDERTAKER

ADDRESS

Wendbrook & Co. 502 E. Pratt

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST.: *7* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *James Nash*(a) RESIDENCE. NO. *Badin N. C.* ST. *Badin N. C.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

10 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Single*6 DATE OF BIRTH (month, day, and year) *Oct 25 - 1888*

7 AGE

31 Years

8 Months

8 Months*23* Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *N. C.*
(State or country)10 NAME OF FATHER *James P. Nash*11 BIRTHPLACE OF FATHER (city or town) *N. C.*
(State or country)12 MAIDEN NAME OF MOTHER *Margt. McCallister*13 BIRTHPLACE OF MOTHER (city or town) *N. C.*
(State or country)

14

Informant *Hospital Record*
(Address) *J. H. H.*

15

Filed *JUL 19 1920*

G. H. Grese

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 18 1920*

17

I HEREBY CERTIFY, That I attended deceased from

*July 8, 1920 to July 18, 1920*that I last saw him alive on *July 18, 1920*

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis(duration) _____ yrs. _____ mos. *27* ds.CONTRIBUTORY *Generalized T.B.*
(Secondary)(duration) _____ yrs. _____ mos. *4* ds.18 Where was disease contracted *North Carolina*
if not at place of death?Did an operation precede death? *No* Date of _____Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *J. Schumacher*, M. D.19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New London N.C. - 7/19/20

20 UNDERTAKER

ADDRESS

Lahner 2212 Braden

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

244900

CERTIFICATE OF DEATH.

150 244900
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 Eager Place ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2204 Eager Place St.; yrs. mos. 1/2 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX,

Male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

July 17, 1920
(Month) (Day) (Year)

7-AGE,

yrs. mos. 1/2 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Balto Md

10-NAME OF FATHER,

Mark Biddison

11-BIRTHPLACE OF FATHER (State or Country),

Balto Md

12-MAIDEN NAME OF MOTHER

Margaret Butler

13-BIRTHPLACE OF MOTHER (State or Country),

Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mark Biddison

(Address) 2204 Eager Pl.

15-

Filed JUL 19 1920 G. H. Grese

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 17, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 17, 1920, to July 17, 1920, that I saw him alive on July 17, 1920, and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation

(Duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. P. Herzog M. D.

July 18, 1920 (Address) 1305 7th St. Balto Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt Carmel

DATE OF BURIAL,

July 18, 1920

20-UNDERTAKER

Philip Herwig Alcaus

HEALTH DEPARTMENT--CITY OF BALTIMORE

244901

CERTIFICATE OF DEATH

78 244901

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2733 Hugo Ave. 9

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Thomas N. Petty

(Residence in Baltimore: No. 2733 Hugo Ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6-DATE OF BIRTH

September 19, 1882
(Month) (Day) (Year)

7-AGE

37 yrs. 9 mos. 27 ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Captain 086
Bug Boat9-BIRTHPLACE
(State or country)

Maryland

10-NAME OF FATHER

Thos. C. Petty

11-BIRTHPLACE OF FATHER
(State or country)

Maryland

12-MAIDEN NAME OF MOTHER

Sarah C. Collison

13-BIRTHPLACE OF MOTHER
(State or country)

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. E. Petty

(Address)

2733 Hugo Ave.

15-

JUL 19 1920

G. H. Grese.

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

July 16, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 14, 1920, to, July 16, 1920,

that I saw him alive on July 16, 1920, and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Purulent Meningitis

Contributory
(SECONDARY)

Pneumonia

(Signed)

July 16, 1920 [Address] 2866 Maryland Ave.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Baltimore

DATE OF BURIAL

July 19, 1920

20-UNDERTAKER

Philip Herwig

ADDRESS

2016 Orleans St.

state CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

844902

CERTIFICATE OF DEATH.

79 844902
18 REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 N. Carlton

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

John. Lawrence

(Residence in Baltimore: No. 222 N. Carlton

St.; 58 yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Col.

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Single

6-DATE OF BIRTH,

July 14, 1862
(Month) (Day) (Year)

7-AGE,

58

If LESS than 1 day.

yrs. mos. ds.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Harmon Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer).

O.M.

9-BIRTHPLACE,
(State or Country),

Baltimore

10-NAME OF FATHER,

John. Lawrence

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Barbara Elliott

13-BIRTHPLACE OF MOTHER
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Barker

(Address) 222 N. Carlton St.

15-

Filed

JUL 19 1920 G. H. Grese.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 16, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

May 10 1920, to July 16 1920,

that I saw him alive on July 16 1920,

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Calculean Heart Disease

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY
(Secondary)

Cardiac Weakness

(Duration) yrs. mos. ds.

(Signed) A. S. Driscoll M. D.

7/17/20 (Address) 1211 Mulberry St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt Auburn Cem

July 18, 1920

20-UNDERTAKER

ADDRESS

Brown & Schrodor

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

2 44903

104 2 44903

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3905 E. Lombard St. ST. 104 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

James J. Davis

(a) RESIDENCE. No.

3905 E. Lombard ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 24-1919

7 AGE

Years

Months

Days

7

23

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore City, Md.

10 NAME OF FATHER

Samuel Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Margaret Timm

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

New York N.Y.

14

Informant (Address)

Samuel Davis, 3905 E. Lombard St.

15

Filed

JUL 19 1920

G. H. G.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 17 1920

17

I HEREBY CERTIFY, That I attended deceased from July 13, 1920, to July 16, 1920, that I last saw him alive on July 16, 1920, and that death occurred, on the date stated above, at 1.30 P. M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

no

(Signed)

1/17, 1920 (Address)

J. J. Schuman, M.D. 330 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross Cem.

July 19 1920

20 UNDERTAKER

ADDRESS

Lilly and Ziehl

403 S. W. 4th St.

CAUSE OF DEATH in plain terms, so that it may be understood by the jury. See instructions on back of certificates.



CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

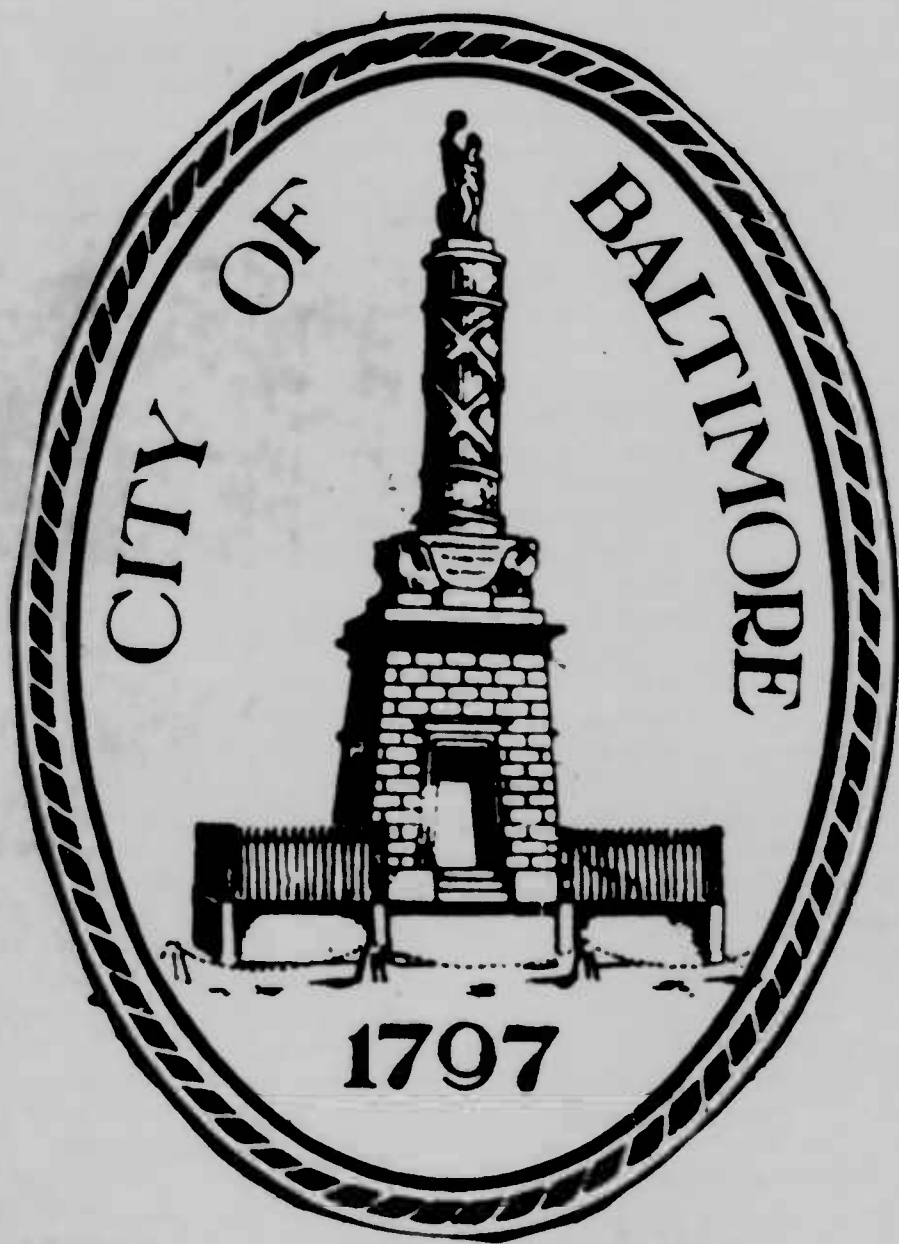
RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 2nd DAY December
OF 1964 THE MICROPHOTOGRAPHS APPEARING
HEREIN STARTING WITH #D 41798 March 30, 1920 AND
ENDING WITH #D 44903 July 19, 1920 ARE AC-
CULATE AND COMPLETE REPRODUCTIONS OF THE
RECORDS OF THE DEPARTMENT OF Health
BUREAU OF Vital Statistics AS DELIVERED
IN THE REGULAR COURSE OF BUSINESS FOR
PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM
MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU
OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC
COPY.

CAMERA OPERATOR: D. McFaul



END OF REEL